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## EDITORIAL NOTES.

**FOUR YEARS OF LIFE**

In this present month of November, just four years ago, the first number of the CALIFORNIA STATE JOURNAL OF MEDICINE, your own journal, made its appearance. We ask you to go back, in your mind, these four years and recall what they have meant to all of us. The starting of the JOURNAL was entirely an experiment. The State Socity had just reorganized, after much discussion and no little difficulty, and the plan of basing membership upon, and having it carried with, membership in a county society was new and untried. Before reorganization, the State Society had about 300 members; immediately after the new plan was adopted and for some months, it had but few more. There were very few county societies in the State and most of those in existence were more theoretical than animate. Such was the condition of things when the JOURNAL was born. Naturally, it had few friends and a not inconsiderable number of enemies; would it live? Fortunately, the friends which it had were not only strong, but loyal, and they fought its fight, and your fight,—for it is your JOURNAL—nobly and well. Sacrifices were made during those first months of which you have never heard and will never know; but the JOURNAL lived and thrived; at first slowly, then more sturdily. The then secretary, Dr. Evans, held well defined views on the question of organization and worked hard for it and for the Society. The Council seconded his every effort, and that of the JOURNAL, and through a committee on organization was very active in prosecuting the formation and stimulation of county societies. Now, after four years, the State Society has a membership, through its affiliated societies, of close upon 2,000 physicians, and the JOURNAL is established on a sound business basis which not even the catastrophe of last April could destroy, though it demolished the inflammable superstructure. It would seem that, in numbers and in machinery and in means for expression and communication, we have, in the State Society, the fundamental elements for an organization.

**ARE WE DOING ALL WE SHOULD.**

But is the attitude of our profession toward the people in this State all that it should be—all that we should make it? Does the organization for the formation of which some of our members have worked so hard and so faithfully, really amount to what it should, by virtue of its numbers and the standing of its individual members? Are we doing all of that work which it is ours, by reason of our choice of life-calling, to do? We have numbers, machinery and means for publicity; but have we given an expression of that potential strength which should be in us? Are we working for the general public welfare, together, harmoniously, intelligently, as we should work, by virtue of that same potential strength which is, or should be, in us; or are we still acting as an incoherent mass of units, ignoring much of the duty we have placed upon ourselves? These are questions which each one of us should take home to himself, and with himself discuss them honestly and truthfully. Is the spirit of charity and brotherly love, of harmony and study, actuating the individual members of our many county societies? Is the young man or the new comer offered the right hand of fellowship and helped over the first rough places? Does the county society mean to you what it should mean, the place where all meet for the betterment and improvement of all, and the increasing of the sum total of medical knowledge; the place where prejudices are laid down and forgotten and mistaken enmities sloughed; the place where friendships are to be made and cemented through intercourse and understanding? Does it mean to you a power for the public good and a means for exercising that care for the public, in general health matters, and that protection from its sins of ignorance, which it is the duty of our profession to exercise?

**GOOD ADVICE.**

How little have we done in comparison with what we should do? Two years ago last April, at the meeting of the Society for 1904, the then President, in his address, placed before us very clearly some essential truths. Have we remembered them, or are they already forgotten?

> "For a doctor to neglect personal attention to civic and political problems is selfish and unjustifiable. His educational advantages, his specific knowledge of sanitary requirements, his trained judgment, his self-restraint and

poise in responsible situations, his familiarity with the vagaries of human nature, and the respect shown him by his fellow citizens, make him eminently qualified for executive work, and even leadership in civic affairs. The man of education, brains, and capability owes a certain part of his day to the community in which he lives, and to the associations with which his personal success and happiness are due. If he does not give it, he is not doing his full duty to mankind. The greater the advantages he possesses, the greater the call to esrve his fellow man. Few men, as a class, have a greater personal capacity than physicians. Therefore, few owe more to the State." *

Are we paying this, our debt to the commonwealth in which we live and in which we find "our personal success and happiness," honestly and fully and conscientiously? Are we devoting any portion of our time to an effort to educate the community to the fact that "pure water, sanitary plumbing, and compulsory vaccination, pay"? Two years ago we witnessed the exalting spectacle of a political demagogue and minature boss, at the solicitation of a small but compact group of fanatical, misguided, long-haired-and-short-brained enthusiasts, forcing through the legislature of our State a bill doing away with one of the laws which protect the people from their own ignorance and folly—the compulsory vaccination law.

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**POLITICS AND ASYLUMS.**

Who is there so hardened that he can no longer feel the least sympathy for those unfortunate individuals who are incompetent to care for themselves and are a burden, when not a menace, to their fellows, through no fault of their own; the insane? Who know so well as physicians, the careful supervision and charitable, intelligent guiding and administration which this unfortunate class should receive? Who can appreciate so well as the members of our own profession the truth of the fact that it is not alone inhuman, it is a crime to permit political favoritism to jeapordize the lives or the comfort or the chance of cure of those who demand our support and our sympathy? Yet, quite recently, we were treated to the spectacle of political influence determining the appointment of a superintendent in one of the largest institutions of this kind in the State; of an old man, who had held the position for years, dexterously juggling it into the grasp of a "rank outsider" (passing by men, of not alone ability and experience, but of years of training), through local political affiliations. And, we dislike to acknowledge it even to ourselves, this was done with the knowledge and connivance of the chief executive of the State, himself a physician. Should we permit the people who are physically under our care, as a profession, to dwell in ignorance of the danger in allowing public institutions intended for the care of the sick or the incompetent, to be subject to politics; and political influence to be placed above professional ability? What institution of this class can be run to its best advantage if political pull rather than good professional service shall be the motive for promotion and advancement? And it is the people themselves who invariably pay the bill of costs for their own ignorance or delinquency. Physicians know these things; but do the people? "Men of lower ideals may deny that official dishonesty and public indecency sap the vigor of a village, town, or city, and inevitably lead not only to higher taxes, but to diminished personal safety."

* H. Bert. Ellis, Journal, May 1904, page 140 et s.

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**SOME OF OUR DUTIES.**

We do not have to search for civic and professional duties to perform, nor for ways in which the potential strength which is in us should be brought out and directed. The people need guiding, educating, protecting; and it is through our societies and the individual members of them, that this strength of our profession should be made manifest. We see charlatans on every hand, not injuring physicians, but deluding and robbing the sick and unfortunate and preying upon the defenseless. We see crooks robbing the child of its richest inheritance from the State—an education—by politically manipulated schools. Graft is but a concrete expression of that fundamental characteristic of human nature, a desire to get something for nothing. We see it on every hand, and we, as thoughtful physicians, realize that in every instance it is the poor man who pays the graft bill; is it not one portion of our duty to preach honesty and thrift as we pass through life? We see men, whose every instinct is but pure commercialism, grow rich from the brains and dollars of physicians whose training and instincts are for professionalism; should not our organizations act for the benefit of all and exert some of our potential strength in the curtailment of this fattening process? We see some of this class defrauding the public, through our unknowing assistance, by coining a few cents worth of drugs and a good many lies, into some wonderful nostrum. Is it not our duty to put a stop to this form of dishonesty by educating ourselves and the public and demanding the truth? We see criminally rich and convicted corporations determining the pittance which they will pay the members of our profession for our work. Is there not ample opportunity here for an exercise of our potential energy? We see, alas! some of our own members, foolishly trading away their professional heritage of self-respect and feeding upon a mess of contract pottage. Is there not room here for charitable education, for kindly persuasion and argument, for right precept and example, that he who has done a foolish thing may see his folly and abjure it?

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**DUTY OF ORGANIZATION.**

As individuals we can do much for civic betterment if we will do each his duty to the community in which he lives, giving some portion of his time for the benefit, not alone of his fellow man, but incidentally of himself; for municipal and State honesty profit every citizen in the commonwealth. But we can

do more as an organized body of intelligent citizens working harmoniously for the common good than we may as individuals. Therefore, it is one of the most important of our duties as individuals to cultivate and make strong our societies—our organizations—and to develop to the uttermost the proper expression of that strength for the public good which we have concealed within us. Merely as individuals, divided, ununited, ignorant of each other's ideas or efforts and of what is being attempted, we could do little to protect the public from ignorant pretenders to medical knowledge. As a handful of more or less antagonistic individuals, it was by a chance that a law properly regulating the practice of medicine—a police law for the benefit of the people—was enacted; and as individuals, not exercising the potential strength of our profession, it has been and will be a contsant struggle to preserve that law from mutilation or emasculation; to say nothing of adding to it some necessary provisions or amending it as needful. As a united and actively organized profession, suggesting, educating, advising, in short, taking our rightful place in the legislative activity of the State, we can do much. But we must often work most unselfishly. Some times it will be our convenience or our pleasure which must yield to the public good; some times our own personal likes or dislikes must go; and again, a personal prejudice must be overcome. But you cannot get something for nothing. We cannot do our plain duty to ourselves and the public unless something in the way of time and personal effort is given by us. And the giving must be unselfish; without thought of personal gain.

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**BOARD OF EXAMINERS.**

A member of the Board of Medical Examiners, in reporting to the Society last April, called attention to this subject in a most direct and forceful manner, and we bespeak your attention to his words, to be found elsewhere in this number. Certain amendments to our present law are required; can we venture to ask the legislature for them without the fear that, the door once opened for amendments, we can keep out any extraneous and undesirable ones? And further, the danger to the public from the rapidly growing number of partially educated osteopathic practitioners, is by no means a small matter. It has been demonstrated in two States that this danger can be averted by placing an osteopath upon the Board of Examiners and requiring all applicants to practice that particular cult to pass the same examinations in the fundamental sciences of anatomy, pathology, surgery, etc., as are demanded from the applicants of any of the other so-called "pathies." But has our organization exhibited enough strength to warrant the attempt to secure such a wise termination of what is a threatening public evil? That is the question asked by the member of the board in his report, and it is the question presenting to each one of us. We have the numbers, but have we the unanimity, the power to act concertedly in advising the legislators on this matter? It will still be some six weeks from the time this JOURNAL reaches you till the time when the legislature convenes; can you educate your representatives to the legislature on these matters in that length of time? Here again some personal feeling may have to be sacrificed to the public good; some of our members, men respected everywhere, have stated that it would be a disgrace to have an osteopath on the Board of Medical Examiners. Is that not placing personal feeling before the public good? This medical act is not for us but for the public; and if in some way that may not be pleasant to us, we can still further protect the ignorant public, is it not our duty to let personal feeling go, and do that thing which will be for the best interests of the public?

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**ORGANIZATION AND EDUCATION.**

We also ask your careful reading of the address by Dr. Aiken before the San Joaquin Valley Society, breathing in every word, organization, fellowship, charity, brotherly love, and devotion to the public good as well as to professional betterment. Some societies there are, to be sure, which are good, live societies; whose meetings are frequent and well attended; whose members are active in the general welfare. But is this true of all? Do you yourself, as you read these words, think that you are doing all your duty to yourself and your community and your fellow physicians? Are you attending your county society as you should and participating in its work as it is your duty? How can we ask the public, or our legislators, to agree with us when we do not agree with each other and do not act jointly and as harmonious units of a great organization? And how can we act together if we do not come together and understand each other? Lack of interest in society work means lack of interest in professional advancement and individual improvement, and that means a poorer class of doctors than the patient is entitled to; and sooner or later the community will find it out. In union, peace, harmony and industry, are advancement, public health protection and public welfare; in apathy, antagonism and indifference, there is no professional progress, no guarding of the public against what we, as educated men, know to be frauds. The four years past have given us fair strength in numbers and in machinery. Now what shall we do? Shall we devote our energies to perfecting our strength, to bring out that vast fund of potential energy which is in us, to striving harmoniously for our own mental betterment and for the protection of the public, its education, its comfort and its safety, or shall we sit quietly in a state of "innocuous desuetude?" Shall we work hard, as individuals, each doing his best, to make more perfect and more enduring and more actively alive for good our county societies, or shall we be apathetic? It is all up to each individual one of us, for each must do his own share of the general work. No one man and no small set of men can do the work that is to be done. The strength of the American Medical Association and of the State Society, and their power for good, lie in the hands of the men who make up the county societies. Are there not enough things for us to do to make it an object

for each and every one of us to see that he leaves nothing undone that will tend to the strengthening and bettering of his county society? The duties placed before us are plain and clear cut; will we shoulder them or ignore them?

## WORK OF THE BOARD OF MEDICAL EXAMINERS—REMARKS BY A MEMBER AT THE THIRTY-SIXTH ANNUAL MEETING OF THE STATE SOCIETY.

By DUDLEY TAIT, M. D., San Francisco.

Five years experience authorizes me to attribute the high per centage of failures during the past year to the presence of new examiners on the board. One year at least is required to familiarize oneself with the subject of examination, and the study of the law may necessitate an additional year or two. The new examiner, however lofty his purpose be, cannot prove an immediate success; he will almost invariably strive to display the extent of his own learning rather than test the applicant's knowledge. Complex, obscure, and catch questions characterize the work of the new examiner. As proof of this contention, I beg permission to cite the markings in the subject of obstetrics, held by a new member of the board. At the August examination, 67 out of 70 applicants failed; whereas at the corresponding examination the year previous, obstetrics being in the hands of an older examiner, not a single applicant failed. The disturbing element represented by the new examiner is apparently well recognized by the Homeopathic State Society, for the two Homeopathic members of the board have remained at their post since their election in 1901. Of the five regular pioneers, only one remains on the board.

Osteopathy—The price paid for our medical law was the Osteopathic Act, which authorizes its licentiates to practice osteopathy and minor surgery. In reality they practice medicine, surgery, obstetrics and the various specialties. The price was already too great in 1901. Today it seems fabulous. During the past five years 490 licenses have been granted by the Osteopathic Board, upon presentation of diplomas, i. e. without examination. California harbors three colleges of osteopathy. Illegal practitioners of medicine and applicants rejected by the medical board supply a considerable and constantly increasing percentage of osteopathic licentiates.

Admitting that we were, and are still, the victims of a corporation vastly superior in organization to the medical profession of this State, how can the evil be attenuated or controlled? First, health officers should be compelled to act in accordance with the decisions of the Attorney General of this state and refuse to accept death certificates signed by osteopaths. Second, by prosecuting osteopaths who practice medicine. Third, by an amendment to the Medical Act permitting the addition of an osteopathic member to the Board of Examiners and subjecting osteopathic applicants to an examination on all the subjects enumerated in the medical law, with the exception of materia medica and therapeutics. The last suggestion may be the most practical. Whether or not the humiliation incident to the official recognition of the osteopaths would be offset by the control of such practitioners, is for you to determine.

It behooves this society to consider most seriously the degree of organization necessary to rescind the many dubious and harassing features of the present medical law and to perfect that especially valuable section relating to unprofessional conduct. Organization, as ideally exemplified in the work of the indefatigable secretary of this Society, is the key note to success. Nothing can be accomplished by doubting Thomases and inconvincible Catalines. A close study of the records of the Board of Examiners prior to 1901, when the present medical law went into effect, discloses the astonishing fact that the law was never enforced in its entirety. Those to whom the enforcement of said law was intrusted knew not the vast importance and scope of certain of its sections relating to the standard of medical schools. A similar condition of inexcusable ignorance and inactivity prevailed under the new law for a period of over two years. During this period complaints and protests were unknown; supreme harmony existed in the profession. Then suddenly the Association standard was flashed before the board, inaugurating a new era in the history of medical legislation of this state. The first note of the death knell of fraud in medical colleges was thus sounded. Harmony was replaced by complaints from applicants; by protests from colleges. But the board possesses no discretionary powers; to all it replied *dura lex sed lex.* Today harmony again prevails in the relations of the board, the applicants, and the medical schools. The numerous irregularities of matriculation and graduation enumerated to you a year ago have not been repeated. All the California schools are apparently obeying both the spirit and the letter of the law.

The board's investigation of preliminary educational requirements and diplomas extends to all applications. The list of applications rejected during the past year comprises one California and six Eastern diplomas. Of what avail is the medical law on the statute books if we continue to ignore its essential features and to look nonchalantly to the Board of Examiners for the enforcement of punitive measures which it is not authorized by law to enforce? I refer to the prosecution of illegal practitioners. County societies, practitioners, the public, all address their complaints to the board. All are apparently oblivious of the fact that the board cannot institute such proceedings; it has consequently never caused the arrest or prosecution of a single illegal practitioner. Three years ago, when it became imperative to test the law in the higher courts, a large number of arrests were made, not by the board but by one of its officers acting in the capacity of a citizen. It was hoped that the experience thus laboriously gained would be utilized by the county societies; but up to the present time their efforts have been either desultory or without practical result. This general apathy regarding the police measure of the medical law, prompts me in submitting for your consideration the advisability of

amending the medical act, making it the duty of the board to prosecute all cases of illegal practice of medicine, the fines collected to constitute a special fund for such prosecutions. A similar clause exists and works satisfactorily in the acts regulating the practice of dentistry and pharmacy.

Reciprocity—Nothing further has been done by the California board in the matter of interstate reciprocity. Our attempts to enter upon reciprocal relations with the District of Columbia were annuled by the passage of the standard-lowering Gallinger bill. You may have recognized in the author of said law the famed opponent of the pure food bill. We believe the equitable solution of the perplexing problem of interstate reciprocity to be the unification of standards through the adoption of the requirements of the Association of American Medical Colleges by the different state legislatures. However, there is apparently no crying demand in this state for reciprocity, and in this regard I would respectfully remind those who decry reciprocity but advocate informal or farcical state examinations, that such a policy would lead to reciprocity and to a reciprocity founded on injustice. During the past five years five California graduates applied for certificates in Eastern and mid-Western states, which furnished California during the same period 160 applicants.

Revocation of Licenses.—The board has devoted a vast amount of time to the enforcement of that part of the law relating to unprofessional conduct and today we report the revocation of the licenses of three notorious advertising abortionists—Josslyn, Meadows, alias Weston, and McGregor Wilson, all of San Francisco. At the next meeting of the board, two more licenses may be revoked for similar reasons. We point with pride to this record unequalled by any other state board. A word now regarding the standard of the requirements. The legal standard in this state is that of the Association of American Medical Colleges for the years of the applicant's matriculation and graduation. We hear it bruited that our standard is constantly being raised. Such a statement is not founded on fact. Our standard has been lowered during the past year, and to our deep chagrin we found the legal preliminary educational requirements lower than those exacted six years ago under the law. This is not the first time that California has taken a retrograde step in educational standards.

During the past year through an oversight in the constitution of the Association of American Medical Colleges certificates from quiz masters were made equivalent to diplomas from high schools. The board has proof of the existence of a mercenary and active traffic in said certificates, whereby numerous thoroughly illiterate students were entitled to matriculate at and graduate from some of the schools of this city. The board was powerless to check this undisguised, nefarious, standard-lowering scheme. But today we bring two documents from the Association of American Medical Colleges, showing a radical change in the legal preliminary educational requirements of this state. (See letters infra.) Thus politics and its dire consequences are eliminated from the medical schools of California.

No law is self operative. Individual efforts are the most cogent factor in advancing the cause of medical legislation. My esteemed colleagues will tell you to what extent the position of board member constitutes a pastime, but I desire to state categorically, although not regretfully, that the work, the dreary, enemy-making, practice-losing work, is done by the members residing here in San Francisco. Apart from the consciousness of duty performed, our reward is the privilege, the honor, of appearing before you with a message of truth, urging that the work go onwards and go upwards.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES.

Columbus, Ohio, March 21, 1906.

Dr. Dudley Tait,
San Francisco, Cal.

Dear Doctor:

By unanimous consent of thirty-five colleges represented at the association meeting in Pittsburg the amendment to Article III., Section 1 (d), suggested by you was adopted. It now reads: "Certificates from reputable instructors recognized by the State Board of Medical Examiners duly authorized by law, or by the Superintendent of Public Instruction *in states having no Examiinng Board,* may be accepted in lieu of any part of this examination."

Section II. This examination must be conducted by or under the authority of the Board of Examination or the Superintendent of Public Instruction of the city or state in which the college is located, as provided for in Article III., Section I. (d).

We hope this will give your board absolute authority to govern entrance examinations. There are only a few states that have no examining board. In these we have to make some provisions for the examination of prospective students.

Very truly,

W. J. MEANS,
Chm. Jud. Coun.

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ASSOCIATION OF AMERICAN MEDICAL COLLEGES.

Chicago, March 28, 1906.

Dr. Dudley Tait,
San Francisco, Cal.

My dear Doctor:—

Your favor of the 24th inst. received. In consonance with a suggestion made by your board, the association at its meeting in Pittsburg unanimously amended subsection (d) section one, article III, and section two, article III as per the slip contained in the enclosed constitution to which I have set the official seal of the association so that you can file the constitution as a matter of record.

The association feels itself indebted to you for calling attention to this matter and stands ready at all times to be of such assistance to you as is possible. A copy of the reprint of our transactions will be forwarded to the members of your board as soon as published.

Very sincerely yours,

FRED C. ZAPFFE.
Secretary.

## THOROUGH ORGANIZATION THE PRESENT NEED OF THE MEDICAL PROFESSION.*

By GEO. H. AITKIN, M. D., Fresno.

The old adage, "In union is strength," was never better exemplified than in the great industrial and commercial undertakings of the day. Organization and co-operation have become synonymous with progress and reform. They dominate every successful enterprise, and should be the head and front of all business relations—the essential factors in the ultimate issue of any great project—the means to a desired end. By them great armies are moved as a unit, and great victories won. By them the entire commerce of the nation is brought within the grasp of organized capital. By them industrial unions and combinations of labor have been formed, which will soon defy all the efforts of corporate power to disrupt. By them, the great religious denominations have become an immense power for good in the spread of the Gospel and teachings of Christianity throughout the entire uinverse.

For the medical profession, organization and co-operation are no less beneficial and imperative, but partly from modesty and partly from indifference, we have been tardy in taking advantage of these powerful forces, so quickly recognized and utilized by industrial and commercial bodies. That we are now awakening to the importance of organized medical activity, for professional advancement and public good, we have but to note what has been accomplished along these lines in years just past. For four years the growth of medical societies throughout the United States has been phenomenal; and there has been a personal interest manifested, which has never before been equalled in the history of the nation. It is estimated that the enrolled membership throughout the country now number not less than 45,000. The membership of the A. M. A. is something in excess of 20,000. It is only a few years since our own State Society numbered but a few scattering hundreds of indifferent inactive members, while now its enrollment approximates 1,800—a rapid increase in numbers, largely due to the personal efforts of a few organizers, very competent in forming county societies, making them the unit which carried with it membership in the State and A. M. A., the latter feature having done more to harmonize and interest the medical profession than all other influences combined.

Consider for a moment what this means! With an organization of nearly 50,000 of the best talent in the land banded together, what a tremendous influence for public good and professional advancement! This large gain in numbers, and the great good accomplished in the past, is only an earnest of what may be done in the future with united effort; but to this end every physician in the land must feel his individual responsibility and take an active part in this important constructive work. If we are to attain to that measure of success to which we are justly entitled, if we are to secure effective medical legislation, a just recognition of medical standards of the army and navy in the halls of Congress, if we are ever to have a medical officer in the cabinet and retain the confidence and good-will of the public, these will only come through organization, united effort and harmony in the medical profession.

Affiliation in the county society is of first importance. To further this end, every reputable physician in the land should have his name enrolled in the county society in which he lives, and not only be enrolled, but become an active working factor in the same. The time is near at hand, if not already in the present, when the physician will find it not only essential to his social position and material welfare, but a necessary requirement for his professional standing, that he be an honorable member of the medical societies to which his brother practitioners are entitled. Especially is this true of the young practitioner, who will need the sympathy, encouragement, council and good-will of those older and more experienced in the service. Nearly all insurance companies, corporations, and other large organizations of trust and profit, take note very quickly whether men seeking positions with them are or are not, members of those medical socities to which they should belong. It is a professional passport and a guarantee of our good standing with the medical profession, and if we have it not, there are grave and just suspicions of our unworthiness.

As you will note, I have made reservations as regards who may be entitled to membership in our medical societies. My own convictions are, and I do not hesitate to assert them, that the physician who is habitually unethical, inherently dishonest and dishonorable with his brother practitioner and fellow citizens, vulgar and ungentlemanly in his conduct, has no rightful claim to fellowship in any medical society. With these disqualifications, the medical society can do such a man little good, while it is more than probable that he would do it much harm. Membership in a medical society will not reform such men; their reformation should come first. He should be made to feel that it means something to be banded together in a profession whose sacred obligations are unsullied honor and the saving of human life; that it means something to have his name enrolled among the heroes and martyrs of medical science.

And as the county society is the portal through which all must pass, and as membership in these entitles him to affiliation in the State and American Medical Association, the highest and best in the land, it is here that the personnel and honor of the profession should be properly safeguarded.

I also note with much regret, the meager attendance and lack of interest in our district society meetings. Are we not losing some of our old time enthusiasm and real love for the practice of medicine? Are we forgetting there are other assets of far more value than dollars and cents, and making the money standard too largely the measure of professional success? We have in the valley nearly three hundred physicians in good standing who should rightfully belong to this society, enrolled as active members, yet there are not to exceed one

* President's address, San Joaquin Valley Med. Soc.

hundred. Instead of an attendance of thirty to fifty as at present, there should be from one hundred to one hundred and fifty at each meeting. Observation will teach you that it is frequently our busiest and most successful practitioners who are found in regular attendance at our medical societies and conventions. Experience has taught them how profitable it is to be there, for they get greater inspiration for their work, the mental horizon is broadened, the getting in touch with one another through this personal contact and exchange of ideas helps to do away with the petty jealousies, dissensions and bickerings which have been the curse of our profession in the past. They become not only better physicians for being there, but better men and better citizens.

No matter how remote, obscure or poor the physician may be, he cannot afford to stand aloof from his brother practitioners, and fail to attend these meetings. To do so, from the mistaken idea that he cannot afford the time required or expense incurred in attendance, is to impoverish himself a hundred fold. It is the everlasting grind and narrow routine of daily life that kills, and he who plods along from year to year, without change, rest and recreation, or strives to run the race alone, does by this very isolation tend to become narrow, warped and soured, disgusted with himself, his profession and the whole world.

Finally, if we come together to-day, with the purely selfish purpose of seeing, hearing and learning, without a thought of reciprocity in giving, building and constructing, we are failing in the highest of our obligations and opportunities. Let us begin the work before us with a broadminded tolerance for differences of opinion, in a spirit of charity, good fellowship and brotherly love, with only this end in view, the uplifting of humanity and the advancement of our profession.

## PROPRIETARY MEDICINES.*

By A. JACOBI, M. D., LL. D., New York.

Goethe once said that the most interesting book that could be written would be a treatise on human errors. In that book, large like a library, the history of quackery—well meant or deceitful—would fill a large place. The distrust of medicine and its powers is as old as the world, for not many ever knew or cared to appreciate what medical science or art is capable or not of accomplishing, or should be held responsible for. Besides, the more uncultured or uncontrolled the human intellect the greater is the predominance of mysticism. In Greece quackery was rife and Aristophanes made it the subject of ridicule. The elder Cato, who advised the use of cabbage against all sorts of disease and employed witchcraft and incantations for luxations, demanded the expulsion from Rome of the Greek physicians. The iatromechanics, who taught the direct interdependence of stars and man and prescribed pills compounded during the conjunction of Jupiter and Venus, and the mediaeval priests who cured with prayers and processions and auto da fes, must surely have met with failures and driven the sick somewhere else. Even the specialists among the saints, St. Anna the ophthalmologist, St. Judas the doctor for cough, St. Valentine for epilepsy, St. Rochus the veterinarian, may have made mistakes and proved incompetent.

Nor was the public always edified by the doctors in other resptcts. Hippocrates complains bitterly of the contests of doctors among each other. More than 2,000 years later Peter Frank thought and advised seriously that the only way to procure an orderly consultation was to call in the police. The maltreatment they were exposed to in the Middle Ages, the contempt in which wounds and ulcers were held, so that the medical faculty of Paris about 1300 commited their candidates by oath not to practice surgery; the barbarous methods of treatment by fire for the dangerous body fluids to which everything was attributed, and afterward the nauseating draughts with which the sick were punished until no better man than Hahnemann tried to redeem them—all that did not contribute to add to the dignity of the profession and to the confidence of the public. All that drove the masses into the arms of the sectarians and the quacks.

Then followed the era of scientific medicine, little more than half a century ago. It was built up on anatomy and physiology and was studied on biologic lines. We should have suspected that the darkness of quackery would disappear before the new light. On the contrary, it has grown in geometric proportions until the accumuled ignorance of quacks and fakers has become a power in every land. The Germans, who like to style themselves the nation of thinkers, have more quacks than any other people. Indeed, Saxony and Bavaria have one quack to two regular physicians; Berlin itself has two to nine. It is in Berlin that 29 per cent of the men among the quacks, including clergymen, workmen, stewards, bathhouse keepers, shepherds and university students —and 14.4 per cent of the women had, before embarking in the practice of doing the sick people, collided with the law courts on account of theft, forgery and sexual crime. It is Berlin that has a judge who, in discharging one of that ilk, said the man deserved the greatest confidence, for he was in possession of very good prescriptions obtained from the servant of a famous dermatologist.

Scientific medicine, as developed by the Vienna school more than fifty years ago, ended in nihilism. Patients, however, would not long be satisfied with being merely percussed and auscultated and autopsied. They had the pardonable wish to be healed and cured. But the only chance they were given was to serve as scientific material. With that they were not pleased and ran off to fill the offices and the coffers of the quacks. Then, after Skoda and Rokitansky, came Virchow, the great man of the century, the enemy of mysticism and obscurantism, the daily discoverer of new facts and new methods in pathologic anatomy, the founder of the cell theory, the great anthropologist and hygienist, the assiduous therapeutist of the individual man and of society,

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the very realization of what Aristotle meant by his "politician," that is, the philosophical and scientific statesman. The great mistake of his life resulted from his democratic confidence in the people. His idealism moved him to believe that the people would instinctively distinguish between the physician and the quack; it was on his advice that the Prussian parliament opened the doors to the fakers and reduced the medical profession to a trade. That was in 1869. He learned too late that people do not know who is who in medicine. People are not even taught by lectures or pamphlets or books, which are superfluous to the physician and not read by the masses. It is their nature to prefer to be in opposition at all hazards. They would rather pay hundreds of millions annually for pseudo-doctrines as displayed in books and journals and for proprietary medicines.

Do you care to know about how many there are? Up to October 12, 1900, there were United States patents for 321 disinfectants, 30 extracts, 48 hair dyes and tonics, 180 insecticides, 376 internal remedies, 56 plasters, 371 topical remedies, 78 veterinary medicines. There were trademarks for drugs and chemicals, 319; medical compounds, 5,794, which increase at the rate of 250 annually. The State Board of Health of Massachusetts has examined about sixty proprietaries for their per centage of alcohol, according to the board's report Howe's Arabian Tonic, "not a rum drink," contains 13.2 per cent.; Parker's Tonic, "purely vegetable," recommended for the cure of inebriates, 41.6 per cent.; Schenck's Seaweed Tonic, "entirely harmless," 19.5 per cent.; Copp's White Mountain Bitters, "not an alcoholic beverage," 6 per cent.; Greene's Nervura, 17.2 per cent.; Hoofland's German Bitters, "entirely vegetable and free from alcoholic stimulants," 25.6 per cent.; Kaufman's Sulphur Bitters, "contains no alcohol," 20.5 per cent. and no sulphur; Whiskol, "a non-intoxicating stimulant," 28.2 per cent.; Golden's Liquid Beef Tonic, "for treatment of alcohol habit," 26.5 per cent.; Hood's Sarsaparilla, 18.8 per cent.; Peruna, 28.59 per cent.; Lydia Pinkham's Vegetable Compound, 20.61 per cent.; Kilmer's Swamp-Root, 7.32 per cent.

We, the doctors, like Virchow, our great master, are responsible for a great deal of this injury that is done to the people. For a baby it is we that prescribe artificial foods, the composition of which we do not know. What Nature gives us at a low price—milk, cereals, salt and sugar—we know and therefore underestimate. Nature is democratic and offers the best she has for the rich and the poor alike. We covet what is unknown and high-priced. We prescribe nostrums of known or unknown composition; the latter is not far from criminal, the first would be excusable but for two reasons. One of them is that the manufacturer looks for the good that he can do to himself, and that factories are not run for your benefit; the second is that an unalterable formula, though its composition may correspond with the label, should not be used by the physician who deals with a variety of cases, ages and circumstances. I do not blame a layman who indulges in self-medication after being treated by his physician with a remedy he sees advertised in the glowing headlines of his daily paper. I have known at least one of the infant foods that was advertised and sold for twenty years, and then publicly discarded by the manufacturer, who claimed to have at last found the proper—probably cheaper—compound. The layman must be excused for refusing to pay a doctor in addition to the advertising expenses of the tradesman.

We physicians do more. We take medical journals that advertise nostrums, that print 'reading notices" of proprietary medicines, old and new; that sell pages of their issue to the trade; that print eulogies of factory products in the shape of "original articles;" that alternate their medical and advertising pages. When I spoke of this abomination before the International Medical Congress of Paris in 1900 a Western medical journal of that style asked the appropriate question: "Who, after all, is this Dr. Jacobi? If it had not been for us, the journals, he would have lived and died in obscurity."

Thus it is that even the mind of the medical man is gradually poisoned. What these sheets do not, perhaps, accomplish fully, the glib agent—sometimes an M. D., who gains access to you by the card he sends in to you—will complete. He dumps his wares—his blotters, ink-stands, paper-knives, pencils, blank books and almanacs—on your table, either personally or through the post office. Well, he can afford it. For the poisonous anilin preparation with sodium bicarbonate which he baptizes with a hybrid name and which is prescribed by thousands of us yields him a thousand per cent. of profit. And how? It has been given admission to what should be your sacred medical book, the United States Pharmacopeia. That is why you find thousands of doctors and hundreds of apothecary shops with stacks of advertising sheets and quackish booklets, but without a United States Pharmacopeia or the American Pharmaceutical Association's formulary. That is why a friend found the expensive prescription of a prominent New York practitioner which read: "Remedium Spontaneum, Radway," and which meant no less than merely cheap "Radway's Ready Relief." The same friend took the trouble of examining 50,000 prescriptions compounded in a number of drug stores. Between 1850 and 1873 he met on the prescriptions of physicians no nostrums and no machine-made tablets; in 1874, 1 in 1,500; between 1875 and 1880, 2 per cent. of them; 1880-1890, 5 per cent.; 1895, 12 per cent.; 1898, 15 per cent.; 1902-1903, from 20 to 25 per cent. In a large drug store, one of the gaudy ones, to which the prescriptions of our fashionable doctors are sent, I was assured that 70 per cent of the prescriptions sent in by reputable physicians contained either nostrums pure and simple or as a part of a compound.

Perhaps it would lead too far to examine all the reasons for that demoralization. But one of them should be generally known and appreciated, which is that there are very few medical schools a graduate will leave, diploma in hand, with the knowledge and practice of writing a prescription. Our medical

schools neglect their duties by thus omitting to teach the art of medicine in combination with what is exclusively and pompously called "science." Let the schools remember what every one of us general practitioners can tell them, that medicine means both science and art. I have here the prescription, dated April 14, 1906, which was given to a patient, who swallowed the stuff, by the professor of pharmacology and therapeutics in one of the great universities between the Atlantic and the Mississippi—very far from the Mississippi—which is a mixture of scientific and queer language, viz., "Bili-salol"—what is bili-solol in the Pharmacopeia?—"0.25, dentur tales doses No. C, three to five pills after meals three times a day."

If there is so much proprietary medicine prescribed, and so much quackery, clear your own skirts, professors and doctors. The quacks and manufacturers smile at our unctuous words and unclean hands.

## GENERAL ENTEROPTOSIS.*

By J. HENRY BARBAT, Ph. G., M. D., San Francisco.

My reason for bringing this subject before you is that it is being overlooked in a large proportion of cases, and thousands of women are leading a miserable existence, and suffering untold torture, because their disease has been improperly diagnosed, and therefore improperly treated. By the term "general enteroptosis" or Glenard's disease, or splanchnoptosis, we refer to a condition of the abdominal contents characterized by a relaxation and lengthening of the peritoneal supports, allowing the viscera to descend below their natural position, especially when the body is upright. While ptoses of the various organs had been recognized by various authors for many years previous, it is to Glenard that we must give credit for having first described, in 1885, the symptom-complex of this condition and devised means to ameliorate the misery of patients suffering from this disorder. His observations have been confirmed by all who have followed this line of work, and the importance of the subject can be understood when we appreciate the fact that from 10 to 25 per cent. of women applying to the gynecologist for treatment, are suffering from this disease.

Women are afflicted about ten times as often as men. Age has no bearing, except that it is uncommon to find a general enteroptosis in children, the kidney alone being displaced. No reference is made to congenital floating kidney. The etiologic factors may be divided as follows:

Hereditary and constitutional.

P. Mathes says that "enteroptosis is a constitutional and hereditary anomaly of the abdominal organs consisting of weakness and absence of vital energy in the whole body. The ptoses are due to insufficiency of the hypoplastic sunken thorax, and secondarily to the weakness of the abdominal walls. The enteroptotic habit is identical with the phthisical habit."

Developmental: In these cases we find girls about the age of puberty assuming a new form of dress, necessitating corsets, which as a rule compress the waist; and with the weight of the clothes, causes a dragging on the viscera in the lower abdomen producing lengthening of the peritoneal supports.

Post partum and postoperative types: After parturition in women in whom the abdominal wall has been overdistended, we find that the recti muscles have been either separated, producing a diastasis, or else have been so stretched that involution has not taken place, allowing the lower portion of the abdomen to balloon out, inviting the descent of the viscera. This is further increased if the patient wears anything tight about the waist line. The same conditions will sometimes obtain after the removal of large abdominal tumors, especially if the patient's general health has been seriously compromised.

Traumatic: Sudden, violent or infrequent exercises, such as falls, jumping, lifting, dancing, horseback riding, coughing, etc., may start some of the organs, and once started the ptosis will gradually become worse.

Nutritional: In which the abdominal wall has been weakened by long continued sickness, or in which the abdominal fat has been increased and diminished frequently.

Renal and pelvic congestion during menstruation, by increasing very materially the weight of the organs, has a tendency to produce ptoses.

The organs are involved in the following order of frequency: Right kidney, transverse colon, stomach, left kidney, liver, spleen. The right kidney is found movable ten times as often as the left, and both kidneys in 15 per cent of all cases.

The right kidney is most often displaced; first, on account of the relation of the liver which is over it, and whose weight and size may vary at different times in the same individual.

Second, the ascending colon, at the hepatic flexure is more movable than the descending colon and splenic flexure, and is a factor in the production of nephroptosis.

Third, the right renal artery is longer than the left, and therefore allows more motion in the right kidney.

Fourth, the suprarenal vein in the right side empties into the vena cava inferior, while on the left side the suprarenal vein joins the renal, affording some support to the left kidney.

Fifth, the second and third portions of the duodenum press on the right kidney.

The transverse colon often begins its descent by being weighed down with fecal matters, which are not removed with sufficient frequency, and ptosis of the transverse colon is a factor in the production of nephroptosis and gastroptosis. Hepatoptosis, while an occasional symptom in general enteroptosis, is also often found alone, and in these cases is due as a rule to trauma. The same may be said of splenoptosis.

The majority of patients suffering from enteroptosis who apply to us for relief, are not aware of the fact that their abdominal organs are displaced and

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usually come complaining of some disturbance of the digestive function associated with an ever constant fatigue and misery, which is relieved only by lying down. When we consider the number of organs involved, we can readily appreciate the fact that the symptoms will differ in different patients according to the causation and amount of displacement of each organ, and the effect on the adjacent organs, and also the effect of the whole malady on the nervous system.

In most cases we find the symptoms due to *movable kidney* attracting the attention of the patient, manifested by pain in the loin coming on after getting out of bed, and increasing materially on exertion, or the placing of any garment making pressure at the waist line.

Dietl's crises, usually begin with nausea and vomiting, followed by headache, pain in the hypochondrium radiating back to the loin, a sense of suffocation and an irresistible desire to remove the clothing and lie down. Intermittent hydronephrosis, by flexion or torsion of the ureter; icterus, by compression of the common duct; gastrectasis, by compression and angulation of the duodenum; hematuria, by angulation of the renal vein, and consequent acute congestion, are all symptoms referable to movable kidney.

Ptosis of the stomach and intestines produces indigestion with fermentation, dilatation of the stomach, gastralgia, retention of food due to lack of muscular tone of the stomach, constipation, autointoxication from the retained feces, mucomembranous colitis and neurasthenia.

Many authors consider that general enteroptosis and neurasthenia are synonymous; others maintain that they are entirely separate disorders. But my conclusions are, that a large number of people have neurasthenia whose abdominal organs are not displaced, and many people have enteroptosis without neurasthenia, and I find that if patients are allowed to suffer from the effects of general enteroptosis for a sufficient length of time, they will become victims of neurasthenia.

Associated with ptoses of the abdominal organs, we must consider the displacement of the pelvic and thoracic organs. The symptom complex of retrodeviations or prolapse of the uterus and enteroptosis are similar, and a ptosis of one organ should lead us to an examination of all the others. Downward displacement of the heart has been noted occasionally, due to traction on the diaphragm by the liver and stomach, and causing more or less serious disturbance of the circulation and heart action.

In the majority of cases the physical examination of enteroptotics is easy because of the relaxed abdominal walls, but occasionally we will find considerable fat still present and it will be rather difficult to feel a movable kidney or determine the position of the stomach and colon. It is best in all cases to go through a routine examination.

After removing the corset and loosening the waistbands the patient is placed in a semirecumbent position, so as to relax the abdominal muscles, and is made to take several deep breaths; the examining hands are placed, one on the loin and the other just below the ribs in front. Just as the patient has taken a deep inspiration, the fingers are brought together as close up under the ribs as possible, and if the kidney is movable it will be prevented from receding and may be palpated and the amount of motility determined. Both kidneys should always be examined. I have had a few cases in which a movable kidney could not be dislodged on certain occasions; I believe this to be due to temporarily increased abdominal tension from gas, or to the patient's inability to properly relax the abdominal muscles.

The borders of the liver and spleen should be mapped out to determine their size. The position of the uterus is then ascertained. The patient is now placed in a standing or sitting position, and the organs again examined to determine the amount of displacement. The position of the heart is also noted. Then stand behind the patient and place the hands on the lower part of the abdomen, lift it up and hold it for a few seconds, and you will find that it immediately relieves the drag which these patients always feel. Let go suddenly, and they will appreciate the benefit which may be obtained by wearing a proper support.

The question which interests the patient is "can I be cured?" Unfortunately we cannot answer in the affirmative, but can give reasonable assurance that we can restore the individual to a fair condition of health and comfort, which will obtain just so long as our directions are accurately carried out. We should also warn all patients with enteroptosis that any carelessness in applying and wearing supporting appliances will be followed by crises which may be more or less serious, and which will oftimes require several weeks rest in bed to remedy, or make an operation imperative. Medical treatment *alone* is of no more value in enteroptosis than it would be in the dislocation of any joint, and I find that most of the patients who come to me with this disease have had all manner of medicine for their stomach and bowels without the slightest permanent relief. It is of course essential in almost all cases to prescribe tonics and laxatives at first, to stir up the partially paralyzed organs, but if these measures are not supplemented by mechanical support of some kind, we will fail absolutely in relieving our patient's condition. Hydriatic measures, in combination with properly regulated exercises, especially in recent cases are to be strongly recommended, and will sometimes result in curing the patient by toning up the abdominal wall and thereby increasing the intra-abdominal pressure.

As a rule however we have to rely on mechanical methods to remedy mechanical diseases, and I will first take up operative proceedures and their application to ptoses of the abdominal viscera. I find as a rule, that when the organs are easily replacable and remain in position with the patient in the dorsal decubitus, no operation is necessary, but if they do not remain placed, operative measures are essential.

The organ to which most attention has been paid has been the right kidney, and in about 10% of cases it will be found necessary to fix it my means of one of the various operations of nephropexy. The

one which I prefer, and which I have been using for the past two years with perfect satisfaction, is as follows:

After making the usual oblique incision, the kidney is thoroughly loosened from all its attachments, especially on its anterior surface, which will often be found closely adherent to the peritoneum and ascending colon. If this separation is not accomplished properly, no benefit will result, and the patient will complain of more pain after than before the operation. Sufficient perirenal fat must be removed from the renal fossa to permit the kidney to come in direct contact with the quadratus lumborum. The kidney capsule is then incised below the level of the hilum, horizontally, and the lower portion detached from the kidney for about half an inch. Then by means of 4 or 5 interrupted formalin catgut sutures, the loosened edge of the capsule is attached to the upper part of the quadratus muscle, or in cases in which the kidney can be placed entirely above the twelfth rib, the skin incision is prolonged upward and the sutures are passed from below upward keeping the needle in close contact with the twelfth rib, and making it emerge between the eleventh and tewlfth ribs. The sutures must all be placed before tying, and it will be found that the kidney will be drawn up so that its lower pole projects only slightly below the lower border of the twelfth rib. By this method the kidney is supported in a cup or sling consisting of its own capsule, and if the peritoneal attachments have been properly separated, there is very little tension on the stitches, and very little pain following the operation. The fasciæ and the skin are closed in the usual manner. No danger need be apprehended in passing the sutures between the eleventh and twelfth ribs, if the needle is made to hug the rib, because even if the pleura should come down lower than usual, it would not be punctured but would be pushed up when the needle emerged on the outside. At the same time I do not believe that any serious result would follow if the pleura were punctured at that point, because the tying of the sutures would effectually close the stitch wounds. If no nerve trunks have been cut or compressed by sutures, comparatively little pain will be experienced and the patient will be about in two weeks.

Operations on all other ptoses require opening of the abdominal cavity. In some cases we will find that a movable liver is causing traction on the stomach and duodenum and also kinking the common or cystic duct, and demands operative measures to fix it in proper position. I have found that occasionally there is a rotation rather than a uniform prolapse, the right lobe projecting down below the umbilicus to such an extent in one case that the lower border of the liver was almost vertical. It is a difficult matter to place sutures which will effectually support an organ as heavy as the liver, and the most satisfactory method which I have found is one devised by Ellsworth Elliott Jr., in which he sutures the round ligament of the liver to the parietal peritoneum, making a sling. This must be supplemented, in cases in which the organ is rotated, by some other fixative measure or no benefit will obtain, and I have in one case of rotated liver caused adhesions between the liver and the diaphram, by rubbing the surfaces with a gauze sponge and then inserting a few sutures to keep the liver in contact with the diaphram. I have on two occasions, in cases of traumatic hepatoptpsis, applied three very heavy catgut sutures directly through the liver substance and the abnominal parietes. The results in these cases have been very good, but there is room for better technic in hepatoptosis.

For gastrophtosis and coloptosis, the stomach and transverse colon have been sutured to the abdominal wall; the omemtum has been used as a sling for the stomach by sewing it to the abdominal parietes, but the results have been far from satisfactory. When gastroptosis is associated with dilatation, gastroplication with posterior gastroenterostromy will unquestionably give the best results, and cases are reported in which relief was obtained only after both operations had been done. Wandering spleen has been treated, in the majority of cases where it has caused trouble, by extirpation, but I do not believe that this should be done unless the organ is diseased or very much enlarged, as it can be fixed to the abdominal wall by roughening the corresponding surfaces and using one or more heavy catgut sutures through the parenchyma of the organ and the abdominal wall.

Ptoses of the pelvic organs require operation more often than those of the abdominal cavity, on account of the impracticability of properly supporting them with mechanical devises. Retrodisplacements of the uterus with the accompanying ptosis of the adnexa, require as a rule an operative proceedure for their correction. Where feasible, shortening of the relaxed supports gives the most satisfactory result and I have a preference for intra-abdominal shortening of the round ligaments in cases of retroflexion, supplemented by shortening of the sacrouterine ligaments in retroversion. Prolapsus uteri is best remedied by ventrofixation and colporrhaphy. When the relaxation of the abdominal walls is due to a diastasis of the recti muscles, it becomes imperative to correct the condition by operation. Any one or all of these fixative operations may be necessary; but it is rare that more than one of the abdominal organs will resist the correct support of the abdominal wall.

I make it an invariable rule to postpone operation, except on the pelvic organs, until a thorough trial has been given the abdominal supporter; then, if it is found that one or more organs resist this means of support, I advise operation. It is to the supporting corset that I especially desire to call your attention. Ever since the publication by Ernest A. Gallant of New York, of his excellent article on Glenard's disease, and his advocacy of correct corsets to remedy the condition, I have been working in the same direction, and with the help of my corset maker have succeeded in relieving a large number of enteroptotics.

In a small proportion of cases, especially if the disease has not been of long duration, the ordinary straight front corset reaching down to the pubes in front, will be found sufficient to support the abdominal contents; but in the majority of cases it

will be found necessary to have the corsets made to order, because if they do not fit accurately they will do more harm than good. I can not do better than to quote Dr. Gallant as to the method of measuring and fitting the supporting corset. "Before attempting to measure a woman for a corset, the intestinal tract should be thoroughly emptied by the administration of laxatives for several days, and immediately preceeded by urination. Having loosened all her clothing, and removed her corset, place the patient on a firm couch or table, head resting on a pillow, legs extended, and secure the following measurements: The dorsal position is absolutely essential. Tie a piece of rope or bandage around the body to mark the waist line. The measurements must be taken next the skin or outside the undervest. Draw the tape snugly, not tightly.

1. Circumference of chest under axillæ? inches.
2. Circumference of bust over most prominent portion of breasts? inches.
3. Circumference at waist line? inches.
4. Circumference of hips at level of anterior superior spines? inches.
5. Circumference of hips over great trochanters? inches.
6. Length, waist line to iliac crest? inches.
7. Length, waist line to top of corset at height patient desires? inches.
8. Length waist line to auxiliary fold? inches.
9. Length waist line to top of symphysis pubis, to median line? inches.
10. Distance between anterior superior spines? inches.
11. Breasts are small, medium, large, flat, rounded, pendulous?
12. Height feet, inches. Weight, lbs. Normal weight, lbs?
13. Right kidney descends inches; is replacable under ribs?
14. Left kidney descends inches, is replacable?
15. Greater curvature of stomach above, on level with or below umbilicus?
16. Lesser curvature can be defined inches below ensiform?
17. Appendix palpable, enlarged, recurrent attacks, last attack? Sensitive at present time?
18. Any abnormalities or dislocations of other organs?

Lacing and putting on corset.—To support the viscera in the diaphragmatic portion of the abdominal cavity, where they have gravitated owing to the semi-opisthotonos posture assumed by the patient, the corset laces must be put in as follows: Beginning with the upper holes, lace down to the sixth from the bottom, then insert a second lace from that point down to the lowest holes, leaving the back open five or six inches. Wrap the corset around the waist, lie down upon the bed or couch, pull the corset well down over the hips, draw up the knees, raise the hips well up from the bed, and fasten the corset from the lowest hook upward. While in this posture, draw on the lower strings, closing the corset as snugly as possible before sitting up; then adjust the upper lace, bringing the upper part of the corset together to a comfortable degree, but never closer than four inches at the top. The wearer will find that the wider open the corset is at the top, the more comfort she will experience in breathing and after eating"

It has been found impracticable to adapt one type of corset to all types of patients, and we have corsets which have besides the lacing at the back, lacing at the sides; and others which have front lacing. I have found, however, that it is almost impossible to adapt any of these types of corset to very short and very thin patients. The short distance between the lower border of the ribs and the spmphysis pubis necessitates short front steels, which if sufficiently powerful to support the viscera, cause great distress, especially when sitting down. In order to overcome this difficulty I have devised a supporting aluminum pad, attached to the end of a truss like steel spring, which is fastened on the otuside of the corset, the front springs of which are softer and which does not have to be laced so tightly. The ordinary truss steel is unsatisfactory, because when it is bent to fit the body, the lower border projects beyond the upper, and will cut the dress unless heavily padded, which is very undesirable.

The less unpleasant we make our remedies, the more apt are our patients to take them, and I have found that the average patient will wear a supporting corset more faithfully than she will an abdominal belt, because it does not involve the placing of an extra garment, and is merely a different type of something to which she has become accustomed. Abdominal bandages and belts, in order to maintain their position, must have under straps which are at best unpleasant, uncomfortable and unclean; but we will find a few patients who cannot wear any form of corset, and in these we must resort to belts or plaster strapping.

When neurasthenia is coincident with enteroptosis, a rest cure is often in order before putting on a corset, and in a large number of cases both diseases will be symptomatically cured by these means.

The following cases are illustrative of some of the types of enteroptosis with which he have to deal:

Mrs. G., aged 65 years, has had five children and has been well up to the past few years when she began to have trouble with her stomach and lost considerable flesh. I saw her for the first time during one of her stomach spells (Dietl's crises) and discovered a mass about the region of the pylorus which was verv tender and somewhat movable, but on account of tenderness and nausea could not be accurately palpated. Examination of the stomach contents negative. Two days after first visit mass had disappeared, but the stomach was still much upset. Examination disclosed loose kidney, which could then be forced down as low as the pelvic brim. Patient was kept in bed two weeks and was then allowed to get up after having had a corset fitted. She gained 37 pounds in the next three months and had no further trouble until one year later, when I was again called and found her with a very severe crisis. She was obliged to remain five weeks in bed before she was able to get up. She had worn her corset faithfully for several months and then became careless, and would get out of bed and remain up for an hour or two before putting on the corset, allowing the kidney to descend and thus be injured rather than benefited by the corset.

Mrs. R. T., aged 24 years, nullipara. Previous history good. I did an abdominal shortening of the round ligaments for retroflexion, one year previous

to her last illness, which began with pain in the right lumbar region, increasing on exertion or long standing. Examination disclosed the right kidney freely movable, but not tender, and easily replacable. I ordered a corset and she was perfectly comfortable until one day she attempted to life a patient; when she experienced a violent pain in the right lumbar region, and as the pain was repeated every time the slightest exertion was made, I decided to do a nephropexy. She has been wearing the corset since the operation, and has been perfectly free from pain. It is noteworthy that her father had suffered from movable kidney and I did a nephropexy on her sister seven years previously, for a very painful movable kidney.

Mrs. A., aged 35 years. I was called first on account of pain in the back, and stomach trouble, which was supposed to be due to a chronic cough. I found a thin, tall, woman with an advanced chronic tuberculosis of the lungs of 8 years standing, and a freely movable right kidney which was easily replacable. The left kidney was movable also, but to a much less degree. She gave a history of getting up in the morning feeling very well, but after putting on her corsets and clothing she would begin to feel pain and misery in the abdomen and back. Every time that she took a carriage ride she would have to loosen her corset and waist bands before getting home, and would almost tear off her clothing to get into bed and obtain relief. I had her fitted with a supporting corset and she has had no pain in the stomach or back since.

Mrs. W., aged 45 years, 4 feet 4 inches high, had been complaining about her stomach for several years, and of late has suffered from retention of food in the stomach with production of gas to such an extent that she was afraid to eat, and was reduced to a mere skeleton, weighing 83 pounds. Examination disclosed a pendulous abdomen with a large hard mass on the right side, extending from the lower border of the ribs to one inch below the umbilicus. This was thought to be a large movable kidney, which was pressing on the doudenum, causing partial obstruction at the pylorus and dilatation of the stomach, extending two inches below the umbilicus. There was slight icterus and chronic constipation. I advised a gastroenterostomy to relieve the dilated stomach and a nephropexy for the supposed movable kidney. On opening the abdomen the mass was found to be the liver, which was rotated so that the right lobe was almost directly under the left, the gall bladder almost horizontal, and the pylorus angulated so as to be almost completely obstructed. I did a posterior gastroenterosotomy according to the method of Roux, using two Murphy buttons. I placed three stitches in the broad ligament to endeavor to draw the liver back into place, but it was impossible to restore it to its proper position. The kidney was not sufficiently movable to warrant interference. She has improved considerably, and has been wearing a supporting corset, which has given her great relief, and at the present time she weighs 105 pounds. I have at present about 100 patients who are wearing corsets for the support of prolapsed viscera, and practically all are enjoying fairly good health, and have been symptomatically cured of their enteroptosis.

## SPASMODIC TORTICOLLIS.

**By P. C. H. PAHL, M. D., Los Angeles.**

By P. C. H. PAHL, B. S., M. D., Los Angeles.

Case I. *1. Woman, 29 years of age, of good family history, head and eyes frequently drawn to one side through spasm; formerly there was pain in the movements, but this, after some fifteen years, ceased. All attempts at a cure proved unsuccessful, no operation was performed. Patient was declared incurable.

Case II. *1. Son of former, 29 years of age. He noticed that his eyes got weak from looking sideways and soon his head commenced spasmodic movements similar to those of his mother. He had been treated by hydrotherapy, massage, electricity and gymnastics; no improvement followed. The division of the sterno-cleido-mastoid was proposed.

Case III. *1. Brother of preceding. At 34 years of age he had influenza and, soon after, he noticed that the head began to make spasmodic movements sideways; when his eyes turned sideways, he said that he then knew that he would have the same trouble as his mother and brother. The man is perfectly healthy and is not much inconvenienced; he has not been treated.

Case IV. *5. A Hebrew drummer, 53 years of age, neurotic family history, noticed vague pains in the right arm; later he noticed pain in the left side of his neck, and soon the arm on that side was involved. Within a year of onset he fell from a car, striking on the right side of his chest and on his right elbow; within a month of the accident the pain on the left side of his neck became much more severe, prevented sleep and caused him much mental distress. To diminish these pains, he turned his head to the right; this alleviated him slightly but, in time, he made this movement to the right without noticing it and thus a tic (spasm) arose. This soon became more troublesome than the pain; his finger placed on the chin prevented the movement temporarily and afforded relief, but the general spastic condition soon became more violent, ceasing only during sleep. Sometimes by making a strong effort he could arrest the movement. Author mentions no treatment.

Csse V. *5 Woman, 50 years of age, has always been nervous. She had at first a slight pain in the back of her head; this troubled her very much, and she noticed a crackling sound when she turned her head backward. In her mental trouble, she repeated this movement frequently until it gradually became automatic. Though the crackling sound is no longer heard, the movements have continued for several years. When her mind is occupied and she does not think of her trouble, it disappears. It even stopped for several months when her daughter was married, as the excitement of the wedding and the meeting of many old-time friends kept her preoccupied. When she returned to her habitual life, the jerking reappeared; author mentions no treatment.

Case VI. *5. Male, 26 years of age, comic singer. One day on the stage he felt a painful spasm in the left arm. At home he rubbed his arm without relief; he was much worried and forced to give up his profession. When he was 29 years old, he noticed, for the first time, a spasm of the muscles of the neck; the head was suddenly jerked to the right and the face directed upward. At first this movement was rare, but gradually became frequent; movement could be stopped by placing right hand on chin. The patient was never hysterical, has never been neurasthenic; no syphilis; no alcohol, and has never been seriously ill. His mother, however, was a diabetic and a brother died of meningitis; a neurotic heredity is not doubtful. No treatment mentioned.

Case VII. *6. Male, mechanic. When 34 years of age, he suffered frequently from vertigo, which disappeared at the end of the year, but he still suffered from frontal headache and tinnitus aurum. A spasmodic movement of the head, which he first noticed when he was about 35 years of age, a year after onset, gave him much anxiety; these movements occurred at short intervals; the head bent over toward the right and backward. It was easily prevented in the beginning but, later, it could only be controlled with the assistance of one or both hands. Sometimes the patient felt as if pressure were brought to bear on the left half of the face, forcing it toward the right, backward and upward. When the patient was accosted or his attention di-

rected to something, the movements stopped; they also disappeared during sleep. The patient was easily excited and got very angry; during the excitement the movements were very much increased; there was no pain. This was doubtless a case of "psychogenous torticollis," which was confirmed by the therapeutic success.

The principal stress was laid on the training of the will power; the passive toleration of habitual movements was combated. Except during moments of great anger, the patient is now quite well, and the pedagogical method has proven a complete success. In these cases, the physician must act as educator.

Case VIII. *7. Woman, 21 years of age, was thrown from a wagon, falling on her head and back; she was stunned but soon recovered sufficiently to walk home. From this time on, she suffered severely with pain in occipital region; she has a spot of great tenderness about an inch to the left and a little above the occipital protuberance, and pressure here will bring on the spasm or increase its violence. In this case, it is highly probable that the spasm is due either to direct lesion of the spinal accessory nerve or to reflex irritation from some anastomosing nerve. I think that the spasm, in this particular case, is reflex due to injury and subsequent inflammation of either the major or minor occipital nerve. If this view be correct, then the treatment operative or counter irritant should be directed to the nerves which are the source of irritation, rather than the nerves causing the spasm. The patient had her sterno-cleido-mastoid muscle cut some months ago, without success. Patient seems to improve; she takes, internally, the fluid extract of gelsemium, beginning with five drops three times daily, increasing the dose one drop daily until at present she takes eighteen drops three times a day; iodide of potash gr. X, bi-chloride of mercury gr. 1-32, have been given. The actual cautery has been applied, three times a week, to the back of the neck and left occipital region with beneficial results.

Case IX. *8. Male, farmer, 29 years of age, has never been sick; no alcoholism; no syphilis. At the age of 9, writers' cramp began to appear; at 18, torticollis appeared for the first time, soon to be followed by spasm of the flexors of the feet and legs, first on the left, and then on both sides; walking is very difficult and torticollis becomes more severe. Clinical examination: Torticollis is due to the contraction of the splenius, trapezius and sterno-cleido-mastoid of the right side; head is bent to the right and backward; this almost permanent position is accentuated every moment by clonic spasms. Normal position can be gained only by will power or by applying the hands; the torticollis disappears entirely during sleep. The hand can hold the pen and take ink from the ink-stand, but if he wishes to trace letters, the fingers are cramped on the penholder and the hand against the paper; writing is very slow and painful and requires a great effort. When standing, the body is not straight but inclined to the left, the right shoulder is raised and the head carried to the right and backward and is agitated by slow contractions. The walk is hard to describe; the right foot is always first and the left follows. the legs move with great difficulty and the patient walks from the pelvis. At every step, the trunk is thrown back and the spasmodic contraction of the muscles of the back and neck are exaggerated; during walking the torticollis is very marked and a spasm of the cheek appears. All tendon reflexes are abolished in the lower and upper extremities; the cutaneous, cremasteric and abdominal reflexes are rather increased; the voice is slow, as if held by a spasm of the lips; the whole picture shows a close symptomatic relation with Friedrich's ataxia and hereditary ataxia. The cerebellar symptom complex dominates in Friedrich's ataxia and the cerebellum seems to be the direct or indirect cause. No treatment given.

Case X. *9. Woman with three children. When she was 39 years of age, while running, she suddenly felt a jerking of the head which caused it to oscillate on all sides. The oscillations persisted for a week; they were quieted by remaining in bed and increased by making movements. At the end of a week, the face was turned toward the left side, while the head was shaken by spasmodic movements which continued for a period of two years, when a portion of the spinal accessory nerve was ex-sected and Keen's operation for the division of the posterior cervical roots was performed. It was found that she received only partial relief from the division of the nerve, and a complete recovery followed three or four months after the latter operation was performed. Electricity, massage, hydrotherapy, anti-spasmodics and all kinds of treatment had been tried without success.

Case XI. *10. Male, 22 years of age, was troubled by drawing of head to the right; complete rest was followed by recovery. For 29 years, he had no especial trouble except a sense of uneasiness in the sterno-cleido-mastoid muscle. At 51, he began to feel a drawing in the neck; at 54, the trouble had increased and spasmodic symptoms appeared. These soon became so aggravated that the head became unsupportable, and his sleep was so much disturbed that hypnotics were constantly necessary. There was marked contraction of the right sterno-cleido-mastoid muscle, by which the head was strongly rotated to the left, at the same time the head was slightly retracted by the contraction of the posterior flexors of occiput. The ex-section of an inch and a half of the spinal accessory nerve was followed by a complete cure but, after a year, the spasm began to recur in the same locality and, in six months, was as bad as ever. Second operation. Search was made for nerve filaments in the scar tissue whereby the sterno-cleido-mastoid muscle was extensively cut and neurectomy was practically supplemented by muscle division. The result was brilliant, being immediate and permanent cessation of spasm.

Case XII. *10. Woman, 40 years of age, spasm in right sterno-cleido-mastoid muscle; re-section of spinal accessory nerve; complete and permanent relief.

Case XIII. *10. Male, 28 years of age, spasmodic twitching of neck of eight months standing. Large doses of quinine salicylate of soda and iodide of potash were used without success. Operation: Incision, four inches in length, along anterior border of sterno-cleido-mastoid muscle; nerve stretched. Twitching disappeared for two months; soon after sterno-cleido-mastoid muscle began to twitch again. There was great improvement, but movements persisted.

Case XIV. *10. Woman, 45 years of age; right spinal accessory nerve resected with immediate benefit.

Case XV. *10. Woman. At 57 years of age, had neuralgia of the head and face; at 62 began to carry head to the left; spasm of the right sterno-cleido-mastoid muscle; trapezius not affected. Operation: Two inches of spinal accessory were removed. Ten days later, there was still some tendency to turn to the left. She was then lost sight of.

Case XVI. *10. Male, 40 years of age, blacksmith. In March, 1872, he had influenza and also sprained his neck; in April, he noticed that he was getting wry-neck, accompanied by spasms; the chin was drawn to the right. Operation: Left spinal accessory nerve was re-sected; relief only temporary. Head is still rotated to the right but, instead of being drawn forward, is now drawn forcibly backward, showing that the posterior rotators on the right have become involved. Patient refused another operation.

Case XVII. *10. Woman, 40 years of age, decided neurotic temperament, has had one attack of pneumonia Soon after, she complained of weakness and prickly sensations in the arms and legs, has typical spasm of left sterno-cleido-mastoid and trapezius muscles, head being turned completely toward the right side. Operation: Long piece of spinal accessory nerve removed; immediate cure of spasm. It recurred some time after but gradually ceased; at present patient shows marked rotation of head to the left.

Case XVIII. *10. Male, 46 years of age, mother neurotic, patient nervous; movements came on gradually, head rotated to the right and bent backwards. Left sterno-cleido-mastoid muscle is tense, as well as the rotators in the back of the neck on the same side. Patient refused operation.

Case XIX. *10. Male. In this case, the posterior muscles of the neck were affected on both sides; head was drawn backward and a little rotated to the left; no movements when lying down, but were increased on walking or working. Treatment, tincture of gelsemium, massage and stretching for seven weeks, resulted as follows: Head was held naturally and patient went to work; massage seemed to be beneficial; there was no operation.

Case XX. *10. Woman, 48 years of age, head drawn to the right and slightly rotated, right sterno-cleido-mastoid muscle rigid and permanently contracted. Operation: Spinal accessory nerve was excised. Head took normal position but the right trapezius again contracted. Patient would not undergo another operation.

Case XXI. *10. Woman, 40 years of age. Head rotated to the left and retracted, right sterno-cleido-mastoid muscle stood out distinctly. In 1894, the spinal accessory nerve was removed and we hope that recovery will be complete. If the head is still rotated and retracted at the end of a month, we shall re-sect the posterior branches of the upper cervical nerves.

Case XXII. *12. Female, dressmaker. When 21 years of age, she had numerous fainting fits; when she was 36, she noticed slight stiffness and occasional twitchings in the neck, which progressively grew worse. Examination showed head turned to left and retracted, face sometimes looking directly upward. A firm grasp of the hand on the nape of the neck greatly diminished the force of the spasm; consequently, a spring clamp was made of light spring steel, broader and heavier, but otherwise similar to ordinary trouser guards worn by bicyclists, with a tail piece from the middle of the spring, running about six inches down the back. When the clothing was buttoned tightly over it, this tail piece helped to keep the spring closely applied; a gentle pressure was thus exerted on the side and back of the neck as far forward as the anterior border of the sterno-cleido-mastoid muscle. The results were best when the collar was worn at about the level of the jaw. The application of the apparatus instantly stopped most of the twitching, although the symptoms would at once recur upon removal of the pressure. After wearing the apparatus constantly for six months, it could be discarded for several hours without recurrence of spasm. One month later, the patient's eyes were examined and astigmatism with oblique axis of both eyes, was discovered and glasses fitted; eleven months later, neither clamp nor glasses had been worn for several months; patient is practically well, with a slight left fixed torticollis of a painless nature remaining.

Case XXIII. *12. Female, 32 years of age, severe spasm, constant action of the right sterno-cleido-mastoid muscle and left posterior cervical rotators. The patient was practically cured in three months by the application of the spring clamp described in Case XXII, supplemented by a careful system of gymnastics (Delsarte movements) especially those of the neck. Very little attention was given to the development of the muscles directly opposed to those involved in the spasm. Exercises were designed to improve the general poise and to secure control throughout the body.

Case XXIV. *13. Female. When she was 25 years of age, she became a sufferer of severe spasmodic wry-neck, commencing a few weeks after a strain of the neck in trying to get into a boat, was spasmodic from the beginning, and, year after year, gradually became more severe. There was violent spasmodic action of the left sterno-cleido-mastoid and trapezius muscles, also spasmodic action in the splenius capitis and other muscles on the right side of the neck. I tried, for some months, the effect of fixation and medical remedies. The effect of a supporting instrument was decided ly benefitcial but it only partially controlled the spasmodic action.

First operation: Left spinal accessory nerve was stretched and some of the filaments entering the sterno-cleido-mastoid muscle were severed, resulting in a relief of spasm on the left side.

Second operation: Ex-cision of a piece of the external division of the great occipital nerve, also the posterior branches of the third and fourth servical nerves. The splenius capitis was separated from the parts beneath and all filaments of nerves passing into it ex-cised. Complete recovery with practically no loss of power from muscular paralysis.

Case XXV. *13. Male, 56 years of age. Without cause, spasms appeared on right side of neck. Drugs had been extensively used without results; operative measures, similar to those in the previous case, were taken and resulted, eventually, in a complete cure.

Case XXVI. *14. Female, 47 years of age; slight sufferer from spasmodic torticollis, which was much increased by the death of her husband; right side affected. Neurotic family history, patient hypochondrical. Treatment, pedagogical, unsuccessful.

Case XXVII. *15. Male, 26 years of age, when his head became twisted to the right; three years later, a spasm of the posterior muscles of the neck developed so that the head was drawn backward; soon the spasm attacked the muscles of the mouth, then those of the back and femurs. All this consumed a period of three years; the spasm remained about stationary for the next 26 years. They were constant at eating and drinking, and even in sleep. Examination: Head was always moving, movements began slowly and were quickly intensified; when they reached the climax, they quickly died out, to begin again in a few seconds. The right sterno-cleido-mastoid muscle was enormously hypertrophied, as well as the neck muscles, which pull the head backward. The prevailing spasms of the posterior neck muscles made this a case of "retrocollis spasmodicus." Operation; re-section of spinal accessory nerve and posterior branches of the first, second and third cervical roots, at one sitting. This was followed by immediate marked improvement; even the next day after the operation, there were only slight vibrations of the chin upward and to the left, which could easily be controlled by the patient. The spasms of the loin muscles, which were absent when lying down but severe when walking, were unaffected.

Case XVIII. *16. Female. At 24, she had a convulsion; at 28, when her husband died, she was in a state of great mental depression. It is stated that she sat on a balcony for hours sewing, and, to distract her attention, she frequently turned her head to the right to look down the street. After a time, the head took this position involuntarily. Finally, spasmodic movements developments followed by pain, more or less acute, in the dorsal region of the vertebral column. Walking, which was impossible without placing the hand to the cheek, aggravated the spasms. Patient mentions no treatment.

Case XXIX. *17. Female. At 14 years of age, she noticed a slight turning of the head, and it soon became much increased; at 17 head rotated to right 30 degrees on a vertical axis, extended to right 20 degrees on a transverse axis and flexed on left shoulder 40 degrees on an antero-posterior axis; spasm was intermittent but never quite absent. With strong effort she could keep her head straight for 30 seconds, but could not walk across the room without supporting her head. The sternal and clavicular end of the sterno-cleido-mastoid was divided by some surgeon; later, one and one-fourth inches of the spinal accessory nerve was ex-cised; the levator anguli scapulae, the scalenus posticus and the splenius capitis were divided without success. A brace was constructed to hold the head straight; conium, in steadily increasing doses, was given, beginning with five drops t. i. d., increasing the dose two drops daily. When vision was affected, dose was decreased and again increased until, in two months, she took eighty drops; a month later, one hundred and forty drops; legs very weak, spasms diminished a little. Injections of an aqueous solution of sulphate of atropin once a day into the muscles affected and into painful points; four drops of a solution, one grain to the ounce, were injected; three days later, six drops; spasms immediately diminished after the injection for several hours. She had some nausea and vomiting. Spasms soon reappeared and patient refused to continue treatment.

Case XXX. *17. Female, 21 years of age, usual history. Gave conium with spinal assistance brace; improvement after a month's treatment. After about a year, she takes one hundred and eighty drops of conium daily. Spasms do not entirely disappear. Patient is discouraged and discontinues treatment.

Case XXXI. Female. When 15 years of age, she was taken with right-sided spasms which gradually became worse until jerks were extremely violent, so as to bring left ear into line with the sternum. The spasms occurred every few seconds and did not entirely cease during sleep; she had been treated with drugs, galvanic electricity, blistering, counter-irritation with the galvano cautery and, finally, had tonsils removed, all without success. Operation; the spinal accessory nerve was ligated with a silver wire as high up as could be reached, the ends of the wire being twisted to insure slight compression; the cure was complete. At the end of three months, the patient was still without the slightest return of spasm and could rotate and retain the head in any position.

Case XXXIII. *19. Female, 39 years of age, who, for four months, had been treated with drugs in large doses, without effect. The right spinal accessory nerve was cut down upon and three-quarters of an inch removed; the patient became practically well.

Case XXXIII. *20. Female, 20 years of age. She had severe spasms of the left sterno-cleido-mastoid; the exciting cause seemed to be the death of a relative whose condition had been unimproved after eight years of various treatments. Operation; the left spinal accessory nerve was stretched and evulsed. A long, slender nerve was pulled from the jugular foramen and four and one-half inches of it excised; no injury resulted from tearing the nerve from its roots; the operation was an immediate success. A year later the patient was still entirely well.

Case XXXIV. *21. Female, 28; spasmodic contraction of left sterno-cleido-mastoid; head jerked down toward left shoulder, face being turned toward the right and chin thrown violently upward. The spasms gradually increased until, at the end of three years, the head was permanently drawn toward the left. Operation; a very much enlarged lymphatic gland was found beneath the sterno-cleido-mastoid muscle, at a point where the spinal accessory nerve enters the muscle. This, with about an inch of the spinal accessory nerve, was removed. Patient was very much benefitted but still had some slight inconvenience from twitches in the neck; steadily improved.

Case XXXV. *22. Male, sailor. When 31 years of age had quotidian ague and, two weeks later, was seized with spasmodic movements of the head; some pain in back and neck. He showed rotary movements of the head to either side, but more particularly to the right; the movements were constant, increased on exertion and ceased during sleep. Operation; one and one-half inches of spinal accessory nerve were excised; cure a complete success.

Case XXXVI. *23. Male, trombone player, 29 years of age. He had been affected with spasmodic torticollis for eight months; spasms, at first slight, gradually increased. Patient was very nervous and excitable; the right sterno-cleido-mastoid and the right trapezius were the only muscle affected. Counter irritants, galvanism, bromides, belladonna, Indian hemp, morphia and atropin had been used without success. Operation; division of the right spinal accessory nerve at a point where it enters the sterno-cleido-mastoid muscle. During the first six days, the patient was free from spasm, then a slight twitching was noticeable, but this gradually disappeared; a complete recovery resulted.

Case XXXVII. *24. Case XXXVII was unsuccessfully treated by ligating the spinal accessory nerve with silver wire.

Case XXXVIII. *25. A case of spasmodic torticollis following injury to a cervical spine was successfully treated by stretching the spinal accessory nerve.

Case XXXIX. *26. (Cotton H. H. P.) Case of spasmodic torticollis treated with thyroid extract.

Cases XL, XLI, XLII, XLIII, XLIV, XLV, XLVI. *27. No particulars given; the patients were operated on by Kocher, who divided the cervical muscles; these cases were seven out of twelve, that were completely cured.

Cases XLVII, XLVIII, XLIX. The patients were operated on by the same surgeon and by the same method, but were only benefitted by the operation.

Cases L, LI, by same surgeon, following the same method, showed no improvement.

Case LII. *28. Male, 29 years of age, developed a clonic spasm of the right side. Treatment: 1-200 of a grain of atropin sulphate was daily injected into the sterno-cleido-mastoid muscle; the dose was gradually increased until, after three weeks, 1-45 of a grain was used; electricity was also administered during the time. The patient became comparatively well and returned to work.

Case LIII. *29. Female, no age given. Some time ago, she sustained an injury to the back of her head, causing clonic spasms in the muscles of the neck; gelsemium was tried without success. Operation: The spinal accessory nerve was exposed and ligated with wire; the wound healed kindly, the wire ligature occasioned no inconveniences. Result not stated.

Case LIV. *31. Male, 26 years of age, physical and mental degenerate and melancholic. He had attacks of excitement and hysterical seizures; he had jerking movements on the left side of his face which raised the labeal commissure; the head was thrown toward the left side. Treatment: Pedagogical, gymnastics, baths and massage. After five months, the patient feels much better mentally and physically, though the torticollis has not disappeared.

Case LV. *31. Male, 25 years of age, nervous degenerate. He had spasmodic condition of left side of neck; patient was slightly improved under hygienic and pedagogical treatment.

Case LVI. *32. Female, 30 years of age. She was taken with spasms in the right sterno-cleido mastoid and the trapezius muscles; the face was rotated to the left side; there was considerable pain.

While supporting the chin with one hand, she could, with slight effort, bring the head into normal position. An apparatus, with a hard rubber chin piece and two upright pieces holding the back and side of the head, was constructed; it was secured to an upright over which was coiled a spiral spring, applied in such a manner that it could exert either a small or large amount of force. The spring action was directed against the spasm.

Case LVII. *34. Male, 50 years of age. After recovering from typhoid, he noticed twitchings of neck muscles, which gradually grew worse; the head was drawn to the right side and the face rotated to the left; the right sterno-cleido-mastoid muscle was shortened. Operation: An incision was made in front of the sterno-cleido-mastoid muscle and the auricularis magnus, which was mistaken for the spinal accessory nerve, was divided. The patient was turned on the abdomen; an incision of three and one-half inches was made through the trapezius and the posterior neck muscles; the posterior division of the second and third cervical nerves was resected; patient did not improve. Two weeks later: this time, I found the spinal accessory nerve, which was re-sected; no improvement. Third operation: I made an incision along the posterior border of the sterno-cleido mastoid muscle and resected a portion of the superficial branches and a portion of the deep branches of the external series of the cervical plexus. Complete cure followed.

Case LVIII. *35. Male, 27 years old, neurotic family history. Right side in spasmodic torticollis treated by pedagogic method and mild faradic current. Patient was cured after forty days' treatment.

Case LIX. *36. Male, 43 years of age, poor family history. After an exposure, he developed spasmodic torticollis of the right side. The sterno-cleido mastoid muscle was much over-developed; trapezius also hypertrophied; the posterior neck muscles on the left side were much more marked than those on the right.

Case LX. *37. Female, no age given, neurotic family history. Four years ago she became melancholy through grief. She developed spasmodic torticollis of the right side; at times, the left side is involved. The change takes place under the influence of deep emotion; she can stop the most energetic spasm by placing the hand on the chin. Patient was very much benefited under pedagogic treatment.

Cases LXI, LXII, LXIII, LXIV, *38, are cases that occurred in the practice of Dr. Brissaud and Dr. Feindel, of Paris, There are no particulars given, except that they all improved under the pedagogic treatment; none were reported as cured.

Case LXV. *40. Woman, 40 years of age. Had spasmodic torticollis for eight weeks. Operation: re-section of spinal accessory nerve, three quarters of an inch of nerve was removed at a point anterior to the sterno-cleido mastoid muscle. This gave only partial relief; there were no more spasms of the sterno-cleido mastoid muscle, but the posterior muscles contracted. Four weeks later, the posterior branches of the second and third cervical nerves were divided, and attachments of muscles were separated from the occiput. After this operation the patient was entirely relieved. Author thinks that success in this case was due to the fact that the operation was done early, before the spasm habit had been acquired.

(Cases LXVI, LXVII and LXVIII occurred in the practice of the author.)

Case LXVI. Male, 50 years of age, a street preacher who gave five or six services a day besides earning his living at some kind of clerical work. This man was, undoubtedly, much overworked and was suffering from a general nervous breakdown. He observed that the muscles on the right side of his neck became spastic and painful; at first this did not give any great amount of discomfort or incapacitate him for his duties but, in the course of three months, because of severe jerking in his neck whenever he attempted any voluntary muscular effort, he found himself quite unable to do anything. Treatment: The patient was treated without benefit, by suggestion, not especially after the method of Brissaud, but by a physician who has some reputation along this line; next the mechanical method was resorted to and a cast, including the trunk and head, was applied (see Fig. 2.) This was worn for a period of six months without any relief, patient refused surgical treatment and, at the present day, four years later, he is in much the same condition.

Case LXVII. Male. Twenty-three years of age. Left side affected. This man was counter in a laundry; he was required to count a large amount of linen in a very short space of time, necessitating very rapid and wearing work. He was compelled to turn his head constantly from one side to the other and to observe, with accuracy, the large number of different garments and other articles of linen as well as to lift numerous heavy bundles on and off the counting table. He noticed a stiffness in and about the muscles of the neck; this soon developed into a jerking movement which became so painful and annoying that it was impossible for him to continue his work. After consulting many physicians some of whom prescribed medicine for application, others medicines to take and one even blistering the unaffected side of his neck, he fell into my hands. The diagnosis was unmistakable. I placed the patient on massage, galvanic and antispasmodics to which, after thirty days, I added a metal support designed to hold the head in the normal position. The patient was sent to the country for a rest and change of scene, all without the slightest benefit, so, at the end of ninety days, the patient demanded surgical interference. The left spinal accessory nerve was first cut, materially lessening the degree of the spasm, but, at the end of three months, the cure was not complete and at this time the author's operation, described in the text, with the exception of the division of the spinal accessory nerve which had been done before, was performed with absolute success.

Case LXVIII. Male. Forty years of age. A grocery clerk. Left side affected. This man had consulted many physicians but his experience was such that his faith in the medical fraternity was very badly shaken. When I told him his condition and stated that a surgical operation would be necessary, he decided to cast his lot with a physician who offered to operate upon him for a small fee and who, I understand, cut some muscles in his neck without benefitting the patient.

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## A CASE OF PLEURAL AND PERICARDIAL EFFUSION.*

By WM. WATT KERR, M. A., M. B., San Francisco.

Your committee on program requested me to read a paper before this society on some topic relating to pleural effusion, but further stipulated that my effusion should not occupy more than the space of fifteen minutes. Probably these conditions can be met most profitably by reporting a case in which the existence of pericardial and pleural effusion was suspected from the symptoms exhibited by the patient, but the opinion was gradually abandoned as, during the progress of the examination, sign after sign was discovered which seemed to negative such a conclusion; and today we might have been patting ourselves upon the back and congratulating ourselves upon the mistakes we had avoided by making repeated examinations, had not the autopsy showed that the pericardial sac contained 2100 c. c., and the right pleural cavity 2250 c. c. of fluid.

Perhaps I am doing wrong in selecting such a topic as this instead of reviewing the work that has been done during the last two or three years, but my apology is that while the complicated cases find their way into our wards and consulting rooms, it is impracticable to embody them in the text-books, and hence it is only at meetings such as this that a general exchange and discussion of such experiences is possible.

The patient was 44 years of age, a laborer by occupation, according to habits a heavy drinker and smoker, while from a medical point of view he appeared to have led a rather strenuous life as in addition to minor ailments he had whooping cough once, measles twice, gonorrhea several times, syphilis, small-pox and typhoid fever in one year. He

* To have been read at the Thirty-sixth Annual Meeting of the State Society, April, 1906.

was admitted to the hospital early in January, 1906, but his earliest symptoms were noticed fully three months prior to that time and consisted of dyspnea and vertigo on exertion, accompanied by dry, hacking cough, and latterly his feet had begun to swell. It is not necessary that you should be detained with a description of the physical signs pertaining to the different symptoms; let it therefore be sufficient to say that the eyes, nervous system, alimentary system and spleen were normal; the urine contained a large amount of albumen with many granular and hyaline casts. The blood examination showed R. B. C. 4,600,000; W. B. C., 10,100, polymorphonuclears 83 per cent, small lymphocytes, 9 per cent, large lymphocytes, 6 per cent, eosinophiles, 2 per cent.

The patient's complexion was somewhat dusky, the respiratory movements were much exaggerated, and he sat up in bed or lay either upon his back or his left side with his shoulders raised and his whole appearance was such as to call forth the remark, "this looks like a case of pericardial effusion." Examination of the heart failed to show any marked bulging the precardia, nor could the cardiac impulse be detected either by inspection or palpation. On percussion the border of the heart-dullness just reached the left nipple line at the level of the fifth rib, while below this it curved sharply inwards so that the area of resonance inside the left nipple line and above the upper border of hepatic dullness was much greater than in the normal heart. Above the fifth rib the line of dullness proceeded inwards and upwards, but about the third rib it ran into an area of dullness that extended outwards towards the left shoulder and disappeared under the outer part of the left clavicle. The cardiac apex could not be located, but the point of maximum intensity of the first sound was just below the left nipple. A systolic murmur accompanied the first sound in the mitral area, while both the pulmonic and aortic sounds were sharper than usual.

Lungs. Over the left apex anteriorly there was dullness extending down to the third rib and passing into the cardiac dullness, and over this area the vocal fremitus, vocal resonance and breath sounds were diminished. Posteriorly over the left lung there was also dullness at the apex, while the breath sounds were high pitched. The right lung anteriorly was resonant at the upper part and auscultation revealed bronchial breathing and a few crepitations; about the fourth rib the resonant percussion note diminished and passed into the hepatic dullness. Posteriorly and in the auxiliary lines there was marked dullness, reaching as high as the level of the fifth dorsal vertebra and over this area the breath sounds, vocal fremitus and vocal resonance were diminished. The intercostal spaces on this side were widely spread and were sucked in with each inspiration as markedly as I ever saw in a case of asthma. The patient's most comfortable position was sitting upright or reclining upon his left side.

Such is as brief a sketch as I can make of the clinical features of the case without sacrificing essential points. Both pleural and pericardial effusion were suspected and their existence frequently discussed, but finally abandoned in favor of mediastinal tumor, a diagnosis that was arrived at by consideration of positive evidences of a tumor and also by observing physical signs that appeared to make the existence of pericardial and pleural effusion improbable.

The positive evidence of tumor consisted in the triangular area of absolute dullness at the upper part of the left lung with its base below the manubrium sterni and its apex disappearing below the outer end of the clavicle; as already stated over this area there was a loss of vocal fermitus, vocal resonance and breath sounds. The idea that a tumor existed, found still further confirmation about ten days later when a large swelling was discovered in the right supra-clavicular space, non-pulsating, non-fluctuating, not attached to the skin and unaccompanied by dilated veins or local edema. We thought that possibly this formation had been overlooked in the earlier examinations, and I may add that it rapidly diminished in size while the patient was taking iodide of potash.

The diagnosis of pericardial effusion was rendered still more improbable because no dullness could be obtained beyond the left nipple line, the maximum intensity of the first sound was just below the nipple, and there was an area of resonance on percussion inside the nipple line that commenced at the upper border of the sixth rib and extended inwards and downwards obliterating part of the area that is usually occupied by cardiac and hepatic dullness.

The decision that the signs on the right side of the chest were not due to pleural effusion was arrived at because (1) there did not appear to be any displacement of the heart to the left side; (2) the intercostal spaces were deeply retracted with each inspiration and hence the opinion prevailed that during inspiration there was a negative pressure within the pleural cavity instead of a distending fluid; (3) the patient breathed better lying upon his left side and it was argued that if the right lung were expanded from the pressure of fluid in the pleural cavity, then he would naturally lie upon his right side so as to give free play to the left lung. Those considerations with the positive indications of a mediastinal tumor seemed to warrant the following interpretation of the physical signs as they existed on the right side of the chest: (1) The percussion dullness was due to thickening of the pleura either from new growth or from a former pleurisy. (2) The bronchial breathing at the upper part of the lung was the result of condensation of the lung in that area from pressure of a tumor. (3) That the retraction of the intercostal spaces indicated an effort to overcome the obstruction to the entrance of air into the lung caused by pressure of a tumor upon the bronchus.

Such was the diagnosis and it would have remained had it not been for the autopsy.

The post-mortem examination was made by Dr. Geo. Blumer, and the following is an epitome of his findings: The abdominal cavity contained about 1200 c. c. of fluid, but the peritoneum was apparently healthy and did not show any signs of old or

recent peritonitis. The liver, spleen, stomach and intestines appeared to be normal with the exception of some passive congestion. The kidneys showed the existence of a subacute nephritis. The tissue of the anterior mediastinum was converted into scar tissue and adherent to the posterior surface of the sternum, in fact, the tissues of the anterior mediastinum were replaced by a new growth, greyish-pink in color, which included the pericardium, aorta and all other structures in the anterior and posterior mediastina. The pericardium was immensely distended and contained 2100 c. c. of fluid. It extended from the mammillary line on the right side to the lateral chest wall on the left.

The right pleural cavity contained 2250 c. c. of fluid almost clear, but bile stained. There were not any signs of recent pleurisy, but the lung was attached by old adhesions to the 4th, 5th and 6th ribs, in the line of their angles over an area about three inches in diameter, the middle and lower lobes were atelectatic, the upper crepitant and congested. On the left side the pleura and lung were diffusely thickened by the neoplasm, the middle and upper lobes being infiltrated with this growth to about the depth of 1.5 c. m. This left lung lay behind the distended pericardium, and along its posterior margin was attached to the spinal column by dense bands.

The right side of the heart was practically empty and the left contained a very small quantity of fluid blood. The tumor in the right side of the neck was a thrombus of the jugular vein.

The following is the report of the histological examination of the various tissues: The tumor varies in appearance in different places. There is a cellular portion made up of masses of small round cells with a deeply staining nucleus and very little protoplasm. These are separated by a fine stroma, and large numbers of thin-walled vessels are present between the cells. In some places the vessels show an obliterative process, some of those which are filled up closely resembling Hassal's corpuscles. The most of the tumor is composed of dense fibrous tissue between the strands of which an occasional round cell is seen.

In the affected portion of the lung the tumor has caused complete occlusion of most of the alveoli, and only a few spaces lined with cuboidal epithelium remain. The lungs outside of the area involved in the tumor show thickening of the alveolar walls from dilatation of the vessels, and a loose exudate in the alveoli. The exudate is composed in places of coagulated albuminous material, in other places of desquamated epithelial cells, red blood corpuscles, and "heart-failure" cells. In a few alveoli polynuclears are present in moderate numbers.

The liver shows a moderate degree of dilatation of the central veins with compression of the surrounding liver cells and slight fatty degeneration of the cells at the peripheries of the lobules.

The spleen shows dilatation of the sinuses with blood, and slight thickening of the trabeculæ.

The kidney shows dilatation of the capillaries with swelling and granular appearance of the parenchymatous cells. There is an occasional fibroid glomerulus, and slight increase in the connective tissue of the medulla.

The adrenals and pancreas show nothing beyond dilatation of the veins.

The testicle shows a moderate increase in the connective tissue rather patchy in character.

Histological diagnosis: Round cell sarcoma of the anterior mediastinum probably originating from the lymph nodes. Infiltration of the lung and neck muscles. Chronic passive congestion of the lungs (with edema), liver, spleen, adrenal, pancreas and kidney. Cloudy swelling of the kidneys. Chronic interstitial orchitis.

It will be remembered that the diagnosis of pericardial and pleural effusion was abandoned because, apart from the positive evidences of a tumor (1) the line of cardiac dullness did not extend beyond the left nipple and did not reach that distance at the level of the sixth rib; (2) the right intercostal spaces were drawn in by each inspiratory movement; (3) the patient was most comfortable when lying upon his left side. How can we reconcile these conditions with the findings of the autopsy?

We can readily understand that the position in which the lung was discovered at the post-mortem examination, was not that which it occupied immediately prior to the death of the patient. So soon as the lung ceased to be inflated by respiration, it would be pushed aside by the weight of the distended pericardium, and this doubtless would be facilitated by the jolting of the viscera which took place when the cadaver was carried from the ward to the morgue and placed upon the table; furthermore, the moment the thoracic vacuum was destroyed by incising the chest wall, the lung would collapse completely behind the pericardial sac. Before death, however, the patient's respiratory capacity was almost entirely limited to the lower and anterior portion of the left lung, which would therefore be distended to its uttermost, overlap the heart as in a case of emphysema, and in this way diminish the area of cardiac dullness and obscure the extent of the pericardial effusion.

The retraction of the right intercostal spaces during inspiration is less easy of explanation. It can not be explained by the presence of adhesions because the area of retraction extended over a surface which was perfectly free; moreover, the following case that came into my wards about ten days later, appears to demonstrate a distinct relation between the amount of fluid in the pleural cavity and retraction of the intercostal spaces.

This second patient had the usual signs of right pleural effusion, i. e., dullness on percussion, diminution of vocal fremitus, resonance and breath sounds with displacement of the heart for more than one inch beyond the left nipple line; but while the patient lay on his left side the right intercostal spaces were drawn in during inspiration. The case was first seen upon Monday morning and absorption of the fluid took place with comparative rapidity, so that upon the following Saturday the cardiac apex was inside the nipple line and the signs of pleural effusion, together with the retraction of the interspaces, were very much diminished, but, in

order that the diagnosis might be established beyond question, by demonstrating the presence of fluid, an aspirator needle was introduced and 500 c. c. of serum withdrawn from the right side. Two things were very evident in this second case: (1) The retraction of interspaces on the affected side diminished as absorption took place; (2) during the morning on which he was tapped, the patient was examined in the upright position and no difference between the movements of the two sides could be detected.

The general impression regarding pleural effusions is that they cause distension, if not actual bulging of the intercostal spaces, and in no instance have I been able to find any reference to retraction, unless it could be attributed to the existence of adhesions between the chest wall and the lung, but the phenomena could not be explained on this basis in either of the cases above reported, because in the first the adhesions were not sufficiently extensive to account for the area of retraction, while in the second the retraction diminished with the absorption of the fluid and now has entirely disappeared.

As already related in the first case the supposition was that this tumor pressed upon one of the large branches of the right bronchus and caused partial collapse of the lung, but Dr. Blumer, in his report of the autopsy, is positive that no such obstruction existed either from the tumor or weight of the distended pericardium, and furtherfore in the second case the simultaneous disappearance of the retraction and fluid indicates that the effusion stood in some casual relation, and that the solution of the difficulty must be found in an answer to the question, What influence has fluid in the pleural cavity upon the lungs?

The statement that pleural effusion compresses the lung is true, but not in the sense frequently accepted, which appears to be that the lung is pushed against the spinal column or chest wall, whereas autopsies show that the unexpanded or atelectatic portion of the lung is that in contact with the fluid. When effusion takes place the size of the pleural cavity is diminished and if the lung were perfectly free, instead of being held in position by its root and surrounding tissues, the result would be a comparatively uniform diminution in the degree of expansion; but as the relation between the lung and the chest wall is definite, the part that suffers will be that in contact with the body or substance that is diminishing the size of the cavity; hence, if there be an enlarged gland, tumor or aneurism in the upper portion of the thorax we find the part of the lung in contact with it is atelectatic, or if the obstruction to expansion be in the lower part of the chest, whether it be solid tumor or liquid effusion, the lower lobe will be unexpanded; in short, it is always the part of the lung in proximity to the obstruction that is carnified, the other parts being unaffected or even over distended.

When air enters the lung of a patient who has pleural effusion, expansion begins in the cells nearest to the bronchi, the lower lobe is forced down into the fluid which rises between the visceral and costal layers of the pleura until its upward progress is arrested by the extremely close apposition of the two surfaces. When this limit of displacement has been reached farther expansion of the immersed lobe is impossible, and therefore in a case of moderate effusion the lung will present an area of complete atelectasis, gradually diminishing as it proceeds upwards, while just above the line of effusion the lung is distended to its utmost. The main bronchi remain open except in cases of large effusion which practically fills the pleural cavity and prevents inflation of the lung. It is this condensation of the peripheral portion of the lung with a patency of the larger bronchi permitting the transmission of air waves from the trachea to the atelectatic periphery that accounts for the persistence of a considerable amount of vocal fremitus, vocal resonance and breath sounds in cases of moderate pleural effusion. Were it otherwise, and the orifices of the bronchi were obstructed by pressure at the root, the air waves would be stifled in their incipiency and absolute stillness would result. When the patient is lying upon his back or the affected side the weight of the liquid is sustained by the diaphragm and chest wall, the lung being unimpeded in its movements except by the diminished capacity of the thoracic cavity; but if he lies upon the healthy side, the fluid, as it gravitates to the lowest point, *i. e.,* towards the spinal column, presses upon the lung and its bronchi thereby increasing the difficulty of inflation, because during the expansion the lung no longer simply meets with the obstruction of diminished space, but at each inspiration has to raise the weight of super-imposed fluid which gravitated towards it when the patient assumed this particular lateral position. The result of this pressure is similar to what we find in obstruction of a bronchus either from pressure or the spasmodic contraction of asthma; namely, the delayed inflation of the lung makes that organ abnormally slow in following the respiratory elevation of the chest wall, and hence there is a tendency towards the development of negative pressure within the pleural cavity during inspiration which manifests itself externally by retraction of the intercostal spaces. Of course the degree of retraction will not be the same in all cases but will vary with the amount of fluid. Thus the effusion may be so small that its weight thrown upon the lung will not be sufficient to interfere with inflation, or it may be so great as to completely fill the cavity and prevent the production of negative pressure under any position. This is the only explanation we have to offer of the observation that in these two cases the intercostal spaces were retracted when the patient lay upon the side opposite to the effusion and that the retraction disappeared as absorption took place.

The patient was most comfortable on his left side in semi-dorsal position, probably because it allowed the freest play of the lung space that remained to him *i. e.,* the upper part of the right lung and the lower and anterior portion of the left.

Probably neither of the effusions were inflammatory in origin but rather of the nature of a hydrothorax and hydro-pericardium due not only to the accompanying nephritis but also to pressure of the tumor upon the cardiac veins and vena azygos.

## SOME ASPECTS OF LATTER DAY IRREGULARISM.*

By JOHN T. RANKIN, M. D., Los Angeles.

An ever recurring question within the ranks of regular medicine is one which would have for its answer the solution of the problem relating to irregularism, and the developments of recent times, instead of detracting from the interest in this question seem rather to add weight to it, for it appears that the originators of new schools, isms, and pathies are vieing with the breakfast food discoverers in the endeavor to furnish the world the very "latest and best" brand of health restorer.

Within the past twenty years, laws regulating medical practice and requiring certain standards for those who would engage therein, have become general. The various healing sects, therefore, have found it somewhat annoying to carry on their vocation without sanction of the authorities, so we see them pleading for separate and distinct legal recognition.

The osteopaths have led the way in this, and success has so crowned their efforts that others are emboldened to solicit the protection and sanction of the law. In our own city, a sect calling themselves naturopaths, have established a school and are clamoring for a place on the statutes. We must not be deceived in believing that they will fail in their aspiration to secure a legal foothold in the State. This clan and their adherents are growing stronger every day. Their cause and doctrines are upheld by a powerful local paper.

Similar organizations are forming in other parts of the country, and, if the past history of sectarian methods is any criterion, we may expect a determined persistent effort on the part of this body for separate legal standing. The fact that every measure of merit which they propose to incorporate in their system is in constant use by the regular school will scarcely have any effect before our lawmakers.

There is, of course, no more need for a separate school along the lines suggested by this band than there is for a separate school of organo-therapy, or sero-therapy, or for schools holding any exclusive ideas of treatment. It should be plain to all men that a physician, in the full sense of the word, looks upon the therapeutic knowledge of the world as a unit which should not be divided into fractional and incomplete elements to fit the narrow gauge ideas of every sectarian band.

Unfortunately, few regard the subject in this way and our lawmakers in particular seem inclined to assist in spreading the gospel of irregularism. It seems, therefore, that the law, instead of acting, as it should, as a barrier to these various organized bands of healers, is being made a protecting wall.

With osteopathy already well entrenched, naturopathy knocking at the doors, and chiropathy on the threshold, we await, with interest, the entrance of other aspirants into the field. No doubt if some thermo-pneumatic individual were to found a school of practice based upon the administration of hot air and should loudly proclaim its all sufficiency in treating disease, he would be able to pump enough of such atmosphere into the ears of sympathetic and gullible legislators to carry any desired measure with votes to spare.

Let us take osteopathy as a general example of these latter day sects, and briefly discuss it from several points of view. I take this body as being the most notable of recent sectarian organizations, and what I may say of them will apply very well to others of like character. The great plea of the osteopaths, when seeking legal recognition, is that their system is a new discovery, and that *it is able to stand alone as a separate and distinct method.* When, therefore, the lawmakers have granted legal recognition to this sect, they have acknowledged their claim, and the lay public naturally accept the endorsement. What effect then, does the legalization of this practice have upon the public? It means that the health seeker, when referred for manual treatment, will not be content with the services of a layman, but will request that one who is duly qualified as a physician, under the law, shall take the case. Legal recognition gives the osteopath the right to call himself doctor and to accept for treatment any case that may apply. The patient may say, "If I am to have manual treatment, I prefer to take it from a physician, from a man who has the same standing, before the law, that you have, and who the law says, is as capable to treat disease as any. When I consulted you about some refractive error of my eyes, you insisted on my seeing a regular licensed physician, an opthalmologist, instead of the optician whom my friends wished me to consult. Your reason for insisting upon this course was that the optician, being a layman, was not a competent person to take charge of such matters, and on account of his ignorance of disease he might do some injury. But now, in this breakdown, you would entrust my case, for manual treatment, to the hands of a masseur, a layman, who knows no more concerning disease than does the optician, whose knowledge you have declared to be insufficient. Does it not appeal to you that, if my case requires this treatment, I should receive it from a legalized physican, who understands the pathology of the disease, and who can consequently go to work with a specific aim in view?"

In such light is the average layman beginning to look upon this question, and the comparison in variable form, is brought to our attention with increasing frequency. In days gone by, the barber being skillful with the knife, was called upon to do the cutting in surgical cases. We are not told that the tailor was selected to sew up the wound, although his dexterity with the needle should have entitled him to this part of the work. An optician might have a perfect understanding of optics, yet we would not allow him to undertake the correction of the ophthalmic difficulties of our patients. Should the photographer, the instrument maker, or electricians, be entrusted with therapeutic or diagnostic Roentgen Ray work, simply because they may be familiar with certain factors which enter into the physics of the Roentgen Ray?

* Read before the Los Angeles County Medical Association, June 22, 1906.

The busy practioner may not have the time, inclination, or equipment to give electro-therapeutic treatment, but surely he does not refer his patients to laymen for this work. But when it comes to manual therapy, we have become so used to sending our patients to laymen for the treatment, that we regard it as a matter of course. Yet the need for professional care and discrimination in the application of manual therapy is as necessary as it is in the application of electro-therapy. Let us ask ourselves, therefore, why, in one case, we will not refer our patient to any but a regular physician, while in the other case we rest content with the services of a layman.

It is my belief that our profession deprecates the fact that we have become somewhat dependent upon non-professionals for the application of manual therapy. Our oversight or neglect in the matter has given the aforementioned organization an opportunity which never would have come had we, as a profession, given our personal attention to this form of treatment.

Manual manipulation, under various names, has been used for centuries as an aid in the treatment of disease and has become an established method in the practice of the regular school. Lack of time in busy professional life caused this work to be resigned almost entirely to the laity, whereby both the manual art and the medical profession have been injured.

I wish to consider the effect which the legal recognition of osteopahy has had upon the one to whom manual therapy has largely fallen, the masseur. Since the advent of this "new pathy" the work of the masseur has dwindled in comparison with previous years. The osteopath has so encroached upon the field of the masseur that it is growing difficult, in many instances, for him to make a living. The result, in many cases, will be one of two things. The masseur will carry on a practice, either openly or surreptitiously, accepting, diagnosing and treating patients, upon his own responsibility, or he will embrace the system which will, in a short time, give him the same legal standing and right to practice that we have. Instead of an assistant, we now have a lawful competitor, who is ready and anxious to draw upon our clientele. Had our competitor gained his right to practice by equal educational and preparatory standards with ourselves, we should not complain. The injustice of the case is in placing fifty per cent of knowledge on a legal parity with the standard, one hundred per cent. If this is not class legislation, then my idea of the meaning of the term is certainly very vague. Such legislation is an act to provide for the "free and unlimited coinage" of incompetent practitioners.

I would not wish it understood that I regard all masseurs as inclined to betray the trust placed in them by the physician. Many are faithful to their charge, but the profession has been betrayed by masseurs and lay helpers so repeatedly that I have come to believe that the average layman has little respect for medical ethics, unless he, in some manner, be constantly profiting by an observance of such ethics. But let there be a decrease or cessation of profit to Mr. Layman and invariably we find him willing to cast our ethics to the ground, not infrequently leaving some trusting medical man in an embarrassing position.

One marked feature of sectarian missionary endeavor is the effort to place the regular school of medicine in a false position before the public. They are constantly aided in this work by various publications throughout the country. Their continual cry is that the regular school is narrow and so restricted in its practice that its members decry all methods of treatment outside of drug therapy. So constantly and thoroughly have they kept up these declarations that the lay public come to believe them and to consider the regular school as the narrowest sect of all. In fact, it is a rare thing to find a layman who understands our position in this matter, and it even appears that many regular physicians fail to realize that the very foundation of our practice lies in its unlimited liberality regarding the choice of therapeutic measures.

As a regular physician, it does not occur to me that there is a single recognized therapeutic method that can not legitimately be used or is not being used by the regular profession. In the face of this is the continual accusation of narrowness by sects whose practice is founded upon a single or restricted therapeutic base.

It should be most helpful to the regular physician to know that there are no limitations or restrictions placed in the way when he comes to administer to his patient. In treatment he has at his disposal the accumulated resources of medical knowledge and is free to use from this source whatever he believes to be the best for his patient. It is not necessary that he become an eddyite or dowieite in order that the power of suggestion might be made to play its part in therapeutics. Suggestion is as old as disease. It always has been and always will be used as an aid to other measures in treatment.

The osteopaths have appropriated to their use an old and valuable system of treatment, claiming a new revelation, a new birth, and giving the infant, born long before Hippocrates, a new name. Should we, on this account, drop manual therapeutics from our practice? Are we to give up our heritage because they claim it as theirs? Or shall we lay hold of our own and use it, as is our right to do?

The doctor does not have to become a follower of the old English bonesetters, or of this new American edition, in order that he may practice that branch of surgery which pertains to the reduction of dislocations, but sailing under the old flag he attacks that abnormal fortress, dislocation, and reduces it.

Is the physician an osteopath when he massages the abdomen in treating atonic conditions of that region, when he manipulate the leg in treating fibrous ankylosis of the knee, or when with the hands he endeavors to stimulate nutritive processes to certain spinal segements or other areas of the body? If this makes him an osteopath now, what did it make him twenty-five years ago when he did those things? In other words, it is perfectly ethical for the practioner to use any form of manual treatment

that he believes will benefit his patient, and he should not consider it beneath his dignity to administer such treatment himself.

The time is here when we should personally administer specific manual treatment. When I say manual treatment, I have no reference to that general shampoo of the body which is given by the average rubber or masseur, but I mean that treatment that has back of it the brains of an educated medical practioner, untrammeled by sectarian isms and pathies. I mean that treatment which has as its rational foundation a knowledge of anatomy and physiology with the training that enables one to make intelligent diagnoses and an understanding of the pathology which we are called upon to correct.

On account of this education and training, the physician only is qualified for the proper use of specific manual therapy, and by its means he may enhance the value of whatever other therapeutic measures are indicated, and he should not weaken the efficacy of his line of treatment by assigning this important branch to laymen.

The basic principle upon which the practice of osteopathy was founded is: That all disease is caused by some anatomical malposition, and that the correction of such abnormality would result in a cure of the disease. Originally, the displacement of some osseous structure was considered as the causative factor, but gradually the practice was broadened and we came to hear of ligament, muscle, bloodvessel and nerve wandering from their created paths. Now, as to the novelty of this claim, there will not be so much dispute, but as to the correctness of it, intelligent members of the medical profession must unanimously dissent. To accept this so-called lesion theory as the etiologic factor of disease and a therapeutic entity is a mistake which ranks with the acceptance of the claims of all other exclusive doctrines in its absurdity. Eliminate, therefore, from osteopathy, this dislocation theory, and we have nothing in this system of treatment differing from the manual treatment advocated and in use by the regular medical profession for many years.

What is to be the outcome of this particular wave of irregularism which has swept over the country in all directions? It is evident that the means which have been used to prevent this erstwhile single method pathy from becoming intrenched around us, have failed to a very large extent. It is true that some States have succeeded in preventing them from securing recognition on their statute books, but if the past decade is any sign of the future, we may expect that ten years hence there will not be a single State holding out against their entrance.

As regular practitioners we should have the safety of the public and the interest of our profession at heart, and should look with disfavor upon anything which has a tendency to lower the standard of our broad-minded school of practice. We believe that no system or school of healing, which is so contracted as to claim that certain restricted methods are all sufficient, should recive favor at the hands of our lawmakers; for such action does lower the high standard of the profession, and its members, by placing on an equal legal footing, men ignorant or deficient, in many of the essentials relating to the diagnosis and treatment of disease. Such action is a menace to the public health, because the law says the sectarian is as competent and capable as any to treat disease. The public believe this and may choose as their physican a sectarian who, unless he be practicing under false colors, is limited in his knowledge and his treatment, and who can not, on account of such limitation, give to his patients the treatment that may be most essential. Therefore, in the interest of mankind and of the high ideals on which our practice is founded, we have felt the necessity for continuous effort in the endeavor to do away with all forms of sectarian practice. The methods taken to thwart the aspirations of the osteopathic cult for legal equality have been, in large measure, unavailing, and if the ways and means used in the past have not been entirely successful, it is reasonable to suppose that they will not be more so in the future. When, therefore, old methods fail, new ones must be tried.

A writer in the *Journal A. M. A.*, January 28, 1905, offers what he regards as a solution of the question. His idea is to establish schools which would give to laymen a two or three year course in manual therapeutics; the instruction to cover the course as given in the first two years in the best medical schools, including materia medica, the graduates to receive some professional title and be legally registered for practice. His thought is that this would give the physician a trained assistant to whom he could safely refer his patients for treatment. That this plan would be a serious mistake, I believe you will agree. It would result in the country being soon filled with the graduates of such schools, a motley crowd, half doctor, half layman. It would put into the hands of thousands of semi-physicians these valuable physical measures. We would have two organized sects, using practically the same treatment; the graduates of one school, however, recognized by law and so by the public, as physicians, while the graduates of the other school would not receive this standing. Consequently, they would not command the confidence of the public as would their competitors. This would, of course, result in discrimination in favor of those who receive full sanction of law to practice the healing art and to call themselves doctors or physicians. Those of the other school being denied this privilege and honor would suffer from the injustice of the conditions, and as it would be but a short step from their ranks to the osteopathic fold, it seems natural that there would result a marked immigration in this direction. Our proposed school would thus act as a generous feeder for this growing sect of irregulars.

What, then, is the solution of this question, for it must, and can be be solved? Let us cease referring to laymen cases needing specific manual treatment, and *let us ourselves personally administer such treatment,* for no one can do this work with such definite and specific aim as can the physician; and it is no more beneath his dignity to fortify the

treatment of a sprained wrist by intelligent manipulation, then it is for him to palpate that wrist in his effort, to determine the amount of injury to the joint, and if the physician's education and training makes him eminently fitted to diagnose the condition, it most certainly marks him, and not the masseur, as the man to treat it, and this applies to any case in which manual therapy would be of service.

As regular practitioners we have no contention as to the value of the manual method, but it is a source of annoyance to us that it has fallen into irregular channels and is used as an exclusive system. But let us not, on this account, drop such a valuable adjunct from our therapeutic column. If we had followed this plan in every case where some sect had seized upon a portion of our treatment resources and announced a new "pathy," we would by this time have been left with but a meager list from which to choose our methods of treatment. We should not be dismayed by these exclusionists who endeavor to appropriate our treatment assets by nicking off a corner here and breaking off a piece there; but let us determine to overthrow these irregular classes by a better, more intelligent, scientific and general use of the methods which they are endeavoring to wrest from our grasp. If every item in our entire therapeutic list were taken up by the profession and thoroughly taught, studied and practiced, I believe that these irregular chips off the old block would soon pass into the history of medicine.

My solution of the problem under consideration you have heard in what has already been said, but in conclusion allow me to emphasize the main thought by a brief repetition. Let us stop assigning our patients to laymen for treatment. Let the profession personally utilize every legitimate and worthy therapeutic measure. Then let it be generally known that there is always opportunity for patients to receive any recognized treatment within the ranks of regular medicine. When these things have come to pass we will see a great host of irregulars looking for a job.

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### SARCOMA: TEN FEET OF INTESTINE REMOVED.

Mr. H., age 22. Family and personal history negative. In August, 1905, noticed something wrong with abdomen, but paid no attention to the slight discomfort. Examination February, 1906. Painful, movable tumor at right of umbilicus. No constitutional disturbance. A few days later the tumor was on the left side.

February 26, 1906, I made an incision, exploratory or operative, and a nodular tumor mass presented in the mesentery of the small intestine. The mass was necrotic in places. The tumor was as large as two fists. The mesentery for several feet along the intestine was greatly thickened. The tumor extended quite to the posterior wall of the abdomen. The peritoneum was dissected from the posterior part of the tumor and a large branch of the superior mesenteric artery was ligated. The mesentery was then divided out to the intestine at right angles after making a double row of ligatures on each side of each divide. The tumor was then dissected loose and with the mesentery roller out of the wound. The cut edges of the mesentery were approximated with catgut. The intestine was divided in the jejunum and about six inches from the ileocecal valve. The ends were anastomosed with a Murphy button. Before dropping the intestine containing the button into the abdomen, all the exposed surfaces were bathed with a 1:500 solution of succinic dioxide. One quart of normal salt solution was left in the abdomen and one pint administered subdermally.

Patient put to bed and cracked ice ordered for thirst. Opiates for pain. No vomiting followed. On fifth day patient drank milk. On eighth day enema gave good result, all enemata previously having failed. Button passed at the end of the sixteenth day.

The microscope showed the tumor to be a spindle called sarcoma. The tape showed that we had removed ten and one-half feet of the small intestine.

September 28, 1906, seven months later, the man is apparently well and says he feels in perfect health. He eats what he likes and has no trouble with his bowels. The patient weighed 125 pounds and was short in stature. Of course we could not measure the intestine that remained, but it appeared shorter than that removed.

H. R. MARTIN, M. D.

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### A CORRECTION.

To the Editor of the State Journal: Unfortunately, an error has inadvertently occurred in my paper in the "State Journal" of September. It was stated that the "American Journal of Dermatology and Genito-Urinary Diseases" was divided into two periodicals. This should have been "The Journal of Cutaneous and Genito-Urinary Diseases," for it was the latter journal which was divided into two periodicals, one becoming The Journal of Cutaneous Diseases, exclusively devoted to skin affections, and the other, The American Journal of Urology, which became the official organ of the National Urological Association.

Respectfully yours,
M. KROTOSZYNER.

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## COUNTY SOCIETIES.

### SACRAMENTO COUNTY.

The regular monthly meeting of the Sacramento Society for Medical Improvement was held October 16, 1906, at the office of Dr. W. E. Briggs, President Wright in the chair.

Present: Drs. Bramhall, W. A. Briggs, W. E. Briggs, Cox, Culver, Duffiey, Fay, Hanna, Hart, Hatch, Henderson, Henrikson, Hesser, James, Look, McGavren, McKee, Parkinson, Pitts, Poore, G. L. Simmons, S. E. Simmons, Sutliff, Twitchell, G. A. White, Wilder and Wright. Visitors: Drs. Barr of Marysville, and Turner of Sacramento.

Minutes of the preceding regular meeting read and approved. A communication was received from the Secretary of the State Society, urging that the committee to act with the legislators from this Senatorial district be appointed at once, and saying that the matter of delaying such appointments until after election, as suggested by this Society at its last meeting, was out of his hands as, under directions from the President of the State Society, about one-half of these committees had already been appointed.

It was duly moved, seconded and carried that the Secretary of this Society be instructed to notify the Secretary of the State Society that the Sacramento Society would furnish the list of names from which its committee is to be appointed at its next regular meeting, which will be after election.

Report of cases: Dr. W. A. Briggs reported a case of furuncle of the scalp treated by the Bier method and followed by a general pyemia. Dr. A. M. Henderson reported a case of carbuncle of the back treated by free crucial incision and curettment and followed by a general pyemia. A discussion followed and became general on methods of treatment of such infections.

The paper of the evening was then read by Dr. Geo. W. Dufficy, title "Surgical Hints." The discussion was formally opened by Drs. Cox and James and then became general.

E. M. WILDER, Secretary.

### SAN JOAQUIN VALLEY MEDICAL SOCIETY.

The twenty-second regular semi-annual meeting of this very thriving Society was held at Fresno, October 9, 1906, and a very excellent program was presented to those in attendance.

The newly-elected officers are: President, Dr. C. T. Rosson of Hanford; Vice-President, Dr. W. W. Cross of Visalia; Secretary, re-elected, Dr. D. H. Trowbridge of Fresno.

The papers presented, most of which will appear in the "State Journal," were as follows:

"A United Medical Profession," W. E. Lilley, M. D., Merced; "Treatment of Umbilical Hernia," A. W. Morton, M. D., San Francisco; "Anesthetics and Anesthesia," C. T. Rosson, M. D., Hanford; "Tetanus—Report of a Case," A. H. Taylor, M. D., Fresno; "Cause of Gall Stones," A. B. Cowan, M. D., Fresno; "Treatment of Gall Stones," J. L. Maupin, M. D., Fresno; "Treatment of Fracture of Lower Jaw," W. W. Cross, M. D., Visalia; "Operations on Thyroid Gland," Wallace I. Terry, M. D., San Francisco; "Exhibition of Strabismus Cases," D. H. Trowbridge, M. D., Fresno.

## PUBLICATIONS.

**Consumption: Its Relation to Man and His Civilization. Its Prevention and Cure.** By John H. Huber. Published by J. B. Lippincott Co., Philadelphia, 1906.

The above named work by Dr. J. H. Huber has been reviewed with great interest. The subject-matter is of vital interest to both physician and layman, taking up as it does the sociological and humanitarian aspects of the subject. It does this in a concise yet exhaustive manner and appeals particularly to the interest of the layman, for as the author states, "Medical science cannot cope alone and unaided with this difficult and prodigious world-problem." It would be impossible within the limits of a brief review to adequately place before the readers of the "Journal" anything like a satisfactory description of the book, for every one of the fifteen chapters, whether devoted to the scientific aspects of the subject or to the economic, legislative or humanitarian phases, is replete with material which should engage the attention of every thoughtful reader, if progress is to be made toward the eradication of this scourge. Considerable space is devoted to sanatoria, to their construction and functions, and descriptions of many of the more important ones both in this country and abroad, are given. The author draws a graphic word picture of the extent to which phthisiophobia has run riot. Much needless suffering has unquestionably been caused because of the hysterical and foolish efforts to isolate the consumptive as one dangerous to the welfare of the public. This groundless fear is even present where one should least suspect its presence. For instance, in one of the best equipped sanatoria in England (which, by the way, the author has not mentioned in his list of English sanatoria), the chapel in connection therewith has a separate entrance and separate pews for the patients!

An interesting chapter is devoted to the work being done by dispensaries, a work which should be taken up and diligently carried on in all cities. The tenement house question is of special interest and should engage the attention of those interested in the upbuilding of San Francisco. The work of the New York Tenement House Commission is reviewed and is emphasized by illustrations taken from the exhaustive report of that body. The entire book is profusely illustrated and is probably the most satisfactory and complete work dealing with these different features of this great problem which has yet appeared.

G. H. E.

### SUPRAPUBIC PROSTATIC ENUCLEATION.

E. Hurry Fenwick, London, Eng. (Journal A. M. A., October 13), thinks that our present technic in suprapubic prostratic enucleation tends (1) to the destruction of the vesical orificial ring; (2) to the wholesale destruction of the prostatic urethra with its afferent seminal ducts; (3) to the rough handling of the membranous uretra. No matter, he says, how the operation is carried out, the original vesical orifice must be left intact and covered with its own mucous membrane. A negelct of this rule in a certain proportion of cases will leave the patient with a warped or narrowed vesical orifice and its attendant evils. Unless there is enough intravesical projection to afford spare mucous membrane to replace that destroyed, such will be the case. To avoid this he has successfully grafted in portions of a sheep's urethra and reports a case in which this was done. He suggests that if a medium of large projecting lateral lobe is present, that it be separately enucleated by an antero-posterior incision, and that the rest of the prostate be removed by an operation described by him in 1904, in which he starts the separation from the prostatic urethra. The forefinger is inserted into the prostatic urethra up to the first joint, the point of the finger is then bent and plunged sideways through the mucous membrane, which in the soft elastic prostate gives readily before the pressure. At once the finger finds itself between the tough capsule of the prostate and the contained adenomatous masses; traveling on without much opposition, the entire lobe is enucleated and generally stripped off the urethra. Great care is taken to keep the floor of the urethra intact and attached to its bed. Usually the adhesions of the lateral walls of the urethra and the lateral lobe are very dense; that part of the canal comes away with the lobe, but the floor is preserved. The lobe is now gently detached from the triangular ligament, so as not to tear or bruise the membranous urethra, and being free, it is pushed or pulled into the bladder; the opposite lobe is treated in a similar way. The finger finally smooths down the mucous membrane in the prostatic urethra, leaving the vesical opening clear and free from projecting tags. It heals by the structure being lined with part of the original prostatic urethra. Fenwick emphasizes the importance of not destroying the ejaculatory ducts, and also of not injuring the membranous urethra in separating the anterior face of the prostate from the face of the triangular ligament. As this is in the future true sphincter of the bladder after prostatic enucleation, it should be very gently and cautiously handled. The article is illustrated.

### ALPHA OMEGA ALPHA.

A chapter of this honor medical society has recently been established in the Medical Department of the University of California. Chapters exist in the University of Illinois, University of Chicago, Northwestern University, Western Reserve University, Jefferson Medical College, University of Pennsylvania, Washington University, Harvard University and Johns Hopkins University.

The members of the California chapter are Drs. Morrow, D'Ancona, von Hoffman, Kerr, Sherman, Huntington, Moffitt, Montgomery, Taylor, Terry, Lewitt, Ebright and Blumer; of the class of '06, Drs. Hayes, Temple, Eidenmuller, Dannenbaum and Adler; and of the class of '07, Messrs. Clark, Alexander and Allen and Miss Paroni.